MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

95C

C4137

CERTIFICATE OF DEATH

Reg. Dist. No. 223-

1. PLACE OF DEATH:

County Montgomery

City or town Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 61 days

Hospital, Institution, or street address where death occurred:

Washington Sanitarium and Hospital

How long in hospital or institution? 61 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State District of Columbia County

City or town Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1619 R Street, N.W.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME MARY EMMA ANSTADT

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife —

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) November 6, 1866

8. AGE: Years	Months	Days	If less than one day
80	5	23	..... hrs. ..... min.

9. Birthplace Selena Grove, Pennsylvania (Town, county, and state)

10. Usual occupation Government Clerk (retired)

11. Industry or business U.S. Government

FATHER 12. Name Peter ANSTADT

13. Birthplace Germany

MOTHER 14. Maiden name Elizabeth Benson

15. Birthplace Baltimore, Maryland

16. Informant Washington San. & Hospital Records

Address Takoma Park, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 2, 1947 (month) (day) (year)

Cemetery or crematory Prospect Hill Cem.

Location York, Pa. 6/2/47.

18. Funeral director The S. P. Ames Co.

Address 2901-14th Street N.W. Washington D.C.

19. 5/29 (Date rec'd by registrar) 1947 J. M. Dudley Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-29- 1947, at 8:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5-26 1947, to 5-29- 1947 and that I last saw h.er alive on 5-29- 1947

Immediate cause of death	DURATION
Terminal Pneumonia	
Due to Cardiac Insufficiency	
Due to Old age	
Other conditions arterio Sclerosis	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE J. Renshaw, MD M. D. or other

Address 28 Carroll Ave, Takoma Park, Md. Date signed 5-29-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04138

Reg. Dist. No. 216

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: Suburban Hospital
How long in hospital or Institution? 13 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Silver Spring
(If outside city or town limits, write RURAL and give nearest town)
Street No. 8207 Georgia Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: John R. Appleton

3. (b) Social Security Number:

4. Sex: male | 5. Color or race: white | 6.(a) Single, married, widowed, or divorced: married

6.(b) Name of husband or wife: Ursula

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Mar. 17, 1877.

8. AGE: Years: 70 | Months: 2 | Days: 1 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Fort Madison, Iowa
(Town, county, and state)

10. Usual occupation:

11. Industry or business: Retired

FATHER
12. Name: George Appleton
13. Birthplace: ? Pa.

MOTHER
14. Maiden name: Margaret Harrison
15. Birthplace: ? Pa.

16. Informant: Mildred Jackson (daughter)
Address: Same

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 21, 1947 (month) (day) (year)
Cemetery or crematory: George Wash. Memorial Park
Location:

18. Funeral director: J. Arthur Baldwin
Address: 254 Carroll St. N.W. Takoma Park D.C.

19. 5/19 19 47 (Date rec'd by registrar) Wm E Jobes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 18, 1947, at 3 40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 30 1947 19.. to May 18 19.. 47
and that I last saw h.i.m alive on May 13 19.. 47

Immediate cause of death: Lobar Pneumonia [6/26/47 okay] — DURATION: 3 days

Due to:

Due to:

Other conditions: Heart failure with decompensation about 6 mths

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.

Autopsy results: Same as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Ephraim Lucrenes M. D.
M. D. or other
Address: Suburban Hosp. Date signed 5/19/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The space is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

4514

159

Reg. Dist. No. 217

1. PLACE OF DEATH:

County Montgomery

City or town Olney, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: The Montgomery County General Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Brinklow

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Bacon

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Col	Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 19, 1947

8. AGE: Years | Months | Days | If less than one day: 9 hrs. min.

9. Birthplace Olney, Montgomery Co, Maryland (Town, county, and state)

10. Usual occupation Infant.

11. Industry or business

FATHER 12. Name Charles Thomas Bacon.

FATHER 13. Birthplace Olney, Maryland.

MOTHER 14. Maiden name Mary Elizabeth Powell

MOTHER 15. Birthplace Daisy, Maryland.

16. Informant Hospital records.

Address

17. Buried (Burial, cremation, or removal. Which?) Date thereof May 21 1947 (month) (day) (year)

Cemetery or crematory Sandy Spring

Location Sandy Spring, Md

18. Funeral director Robert L. Snowden

Address Rockville, Md

19. May 21 1947 (Date rec'd by registrar) Gertrude B. Lawler Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 20 19 47 at 7:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 19 1947 to May 20 1947 and that I last saw h.i.m. alive on May 20 1947

	DURATION
Immediate cause of death	
Prematurity	5 mts.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE [signature] M. D. or other

Address Sandy Spring, Md Date signed 5/22/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correctness is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04139

93d

CERTIFICATE OF DEATH

Reg. Dist. No. 223

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County

City or town 605 Maple ave Takoma Pk Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:
Jellife Rest Home

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State DC. County

City or town
(If outside city or town limits, write RURAL and give nearest town)

Street No. 9115 4th St NW.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Mary E Bailey

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 27 - 1857.

8. AGE: Years 89 | Months | Days | If less than one day hrs. min.

9. Birthplace Washington D.C.
(Town, county, and state)

10. Usual occupation Domestic Worker

11. Industry or business

FATHER
12. Name William Bailey
13. Birthplace Penn

MOTHER
14. Maiden name unknown
15. Birthplace

16. Informant Rest Home Record
Address

17. Burial Date thereof May 28-1947
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Glenwood Cemetery

Location Washington, D.C.

18. Funeral director J.Wm Lee Sons Co

Address 2000 4th St NW DC

19. May 27 1947 J. Wm. Lee
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 25 19 47, at 1155 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1st 19 47 to May 25th 19 47

and that I last saw h.. alive on May 25 19 47

Immediate cause of death Arteriosclerotic heart disease — DURATION: years

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations —

Date of op.

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE C. P. Ryland M.D.
M. D. or other

Address 4901 Massachusetts Ave NW Wash 16 DC Date signed 5-25-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04140

Reg. Diat. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2yrs, 5mos, 9days

Hospital, Institution, or street address where death occurred:

U. S. Naval Hospital, Bethesda, Md.

How long in hospital or institution? 2yrs, 5mos, 9days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No. 514 15th Stree t, Southeast

(If rural, give LOCATION)

2.(a) If veteran, name war: WW I & WW II

3.(a) FULL NAME

BARBERA, Ferdinand

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Mary H. Barbera

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1 September 1890

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
56	8	28		

9. Birthplace: Italy (Town, county, and state)

10. Usual occupation: U. S. Navy

11. Industry or business

FATHER — 12. Name: Anthony Barbera

FATHER — 13. Birthplace: Italy/dec.

MOTHER — 14. Maiden name: Rose Natalia

MOTHER — 15. Birthplace: Italy/dec.

16. Informant: Wife: Mrs. Mary H. Barbera

Address: 514 15th St.m SE, Washington, D. C.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 6-2-47 (month) (day) (year)

Cemetery or crematory: Arlington National Cemetery

Location: Arlington, Virginia

19. Funeral dirsctor: W. W. Chambers, Co.

Address: 517 11th St. SE, Wash., D. C.

19. 5-29 19 47 (Date rec'd by registrar) Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 29 May 19 47, at 3:55 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 20 December 19 44, to 29 May 19 47 and that I last saw him alive on 29 May 19 47

Immediate cause of death	DURATION
Myeloma, Multiple	2½ yrs.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results: none performed

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: T. M. FOLEY JR, CDR MC USN M. D. or other

Address: USNH, Bethesda, Md. Date signed: 5-29-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

6/10/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

74a

04141

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 18 days
Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.
How long in hospital or institution? 18 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Va. County:
City or town: Alexander
(If outside city or town limits, write RURAL and give nearest town)
Street No. 3916 Bruce St., Alexander, Va.
(If rural, give LOCATION)
2.(a) If veteran, name war: 2ndWW

3.(a) FULL NAME: BARTHOLOW, Donald Kenneth

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	married

6.(b) Name of husband or wife: Elizabeth Bartholow
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Oct. 1, 1913

8. AGE: Years	Months	Days	If less than one day
33	7	22	hrs. min.

9. Birthplace: Iowa
(Town, county, and state)
10. Usual occupation: unemployed
11. Industry or business:

FATHER
12. Name: BARTHOLOW, Ira
13. Birthplace: Ill.

MOTHER
14. Maiden name: ~~PAULMER, Reta~~ Lela Lawson
15. Birthplace: Iowa

16. Informant: wife: Mrs. Elizabeth Bartholow
Address: 3916 Bruce St., Alexander, Va.

17. burial (Burial, cremation, or removal. Which?) Date thereof: 5-23-47 (month) (day) (year)
Cemetery or crematory: Ottumwa Cemetery
Location: Ottumwa, Iowa

18. Funeral director: W. W. CHAMBERS
Address: 1400 Chapin St., N.W., Wash., D.C. adk

19. 5-23 1947 (Date rec'd by registrar) Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 23 May 1947 at 7:24A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 5 May 1947, to 23 May 1947 and that I last saw h... im ...alive on 23 May 1947

	DURATION
Immediate cause of death: Chronic Leukemia Myelogenous	
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results: Confirmed above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: H. L. JONES, Jr., Cdr. (MC) USN
M. D. or other
Address: USNH Bethesda, Md. Date signed: 5-23-47

M

MARGIN RESERVED FOR BINDING

I

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

6/14/47

Evidence for change of birthdate and age shown on:

C4142

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

95b

FILM No. G 110 MAY 27 1947 CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County MONTGOMERY

City or town Bethesda

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 13 days S.

Hospital, Institution, or street address where death occurred: Suburban Hospital 8600 Old Georgetown Road, Bethesda 14, Md.

How long in hospital or institution? 13 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Va County Arlington

City or town Arlington

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1012 N. Quincy St

(If rural, give LOCATION)

2.(a) If veteran, name war WW I

3.(a) FULL NAME Mary J. Beach

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	White	MARRIED

6.(b) Name of husband or wife OAKLEY R BEACH

6.(c) If alive, give age 49 years

7. Birth date of deceased (mo., day, yr.) August ~~6~~ 2, 1891

8. AGE: Years	Months	Days	If less than one day
55~~49~~	9	9	....hrs. ....min.

9. Birthplace Westmorland Co. Virginia (Town, county, and state)

10. Usual occupation Home Maker

11. Industry or business Own Home

FATHER 12. Name Charles Hall

13. Birthplace Pohick, Virginia

MOTHER 14. Maiden name Alice R. Olverson

15. Birthplace Hague Virginia

16. Informant Husband Oakley R. Beach

Address 1012 N. Quincy St. Arlington Va.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 14 1947 (month) (day) (year)

Cemetery or crematory Arlington Nat. Cem.

Location Arlington, Virginia

18. Funeral director W. E. Fitzgerald & Son

Address 3245 Wilson Blvd at.

19. 5/12 1947 Mrs E Jobes Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH May 11 1947, at ....M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1937 19.... to 11 May 1947

and that I last saw her alive on ....19....

Immediate cause of death	DURATION
CEREBRAL EMBOLISM	12 HRS.
Due to EMBOLUS FROM LEFT AURICULAR THROMBUS.	?
Due to RHEUMATIC HEART DISEASE	10 YRS
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations.... Date of op....

Autopsy results Rheumatic Heart Dis, Thrombus, Lt. Auricle.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.... Date of....

Where did injury occur? .... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ....

Means of injury .... Injured at work?

23. SIGNATURE Charles R. L. Talley M.D. M. D. or other

Address 1601 Eye, Wash D.C. Date signed 13 May 1947

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

186a 04143

Reg. Dist. No. 713

1. PLACE OF DEATH:

County Montgomery

City or town Takoma Park Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 50 days

Hospital, institution, or street address where death occurred: Washington Sanitarium + Hosp

How long in hospital or institution? 50 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State ..... County .....

City or town Washington D.C.
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1375 Locust St. N.W.
(If rural, give LOCATION)

2.(a) If veteran, name war .....

3.(a) FULL NAME Mrs. J. Katie Beck

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Fe	Wh	married

6.(b) Name of husband or wife Mrs. William E. Beck Sr.

6.(c) If alive, give age 79 years

7. Birth date of deceased (mo., day, yr.) Jan 6, 1868

8. AGE: Years	Months	Days	If less than one day
79			..... hrs. ..... min.

8. Birthplace Washington D.C.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name James A. McCathran

13. Birthplace Scotland

MOTHER 14. Maiden name Catherine Peake

15. Birthplace Washington D.C.

16. Informant Hospital Record

Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 15, 1947 (month) (day) (year)

Cemetery or crematory Cedar Hill Cem.

Location 4000 Suitland Rd. S.E.

18. Funeral director G.T. Hines Co.

Address 2901-14th St. N.W.

19. May 14 1947 (Date received by registrar) J. Wilmer Dodd Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 12 1947, at 5:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 15 1947, to May 12 1947

and that I last saw h[illegible] alive on May 12 1947.

Immediate cause of death	DURATION
Cardiac dilatation	2 hrs.
Due to Old age, fract. of vertebrae decubitus ulcers	3 mo
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations —

Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) FELL DOWN STAIRS

Means of injury ..... Injured at work?

23. SIGNATURE Wm. A. Shannon M.D.
M. D. or other

Address 113 Carroll St. N.W. Wash. D.C. Date signed 5-12-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 97

C4144

CERTIFICATE OF DEATH

Reg. Diat. No. 213

1. PLACE OF DEATH:
County: Montgomery
City or town: Rockville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, institution, or street address where death occurred:
531 W. Montgomery Ave.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Rockville
(If outside city or town limits, write RURAL and give nearest town)
Street No. 531 W Montgomery Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war: No

3. (a) FULL NAME: John William Benson

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Elizabeth Benson
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): September 25, 1861

8. AGE: Years	Months	Days	If less than one day
85 ~~86~~	7	29	hrs. min.

9. Birthplace: Rockville, Md.
(Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business: Farming

FATHER
12. Name: James R. Benson
13. Birthplace: Maryland

MOTHER
14. Maiden name: Lucinda Miller
15. Birthplace: Virginia

18. Informant: Miss Gladys Benson
Address: 531 Montg. Ave. Rockville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5-27-47 (month) (day) (year)
Cemetery or crematory: Rockville Union Cemetery
Location: Rockville, Maryland

18. Funeral director: Wm R. Humphreys
Address: Rockville, Md.

19. 5-24 1947 (Date rec'd by registrar) E P Thompson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 24 1947 at 7:50 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 16 1947 to May 24 1947 and that I last saw him alive on May 22 1947

Immediate cause of death	DURATION
acute dilatation of heart	suddenly
Due to: arterio-sclerosis	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: G. N. Hartley M.D. M. D. or other
Address: Rockville, Md. Date signed 5/24/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (73-U)

CERTIFICATE OF DEATH

04147

Reg. Dist. No. 216

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 days
Hospital, institution, or street address where death occurred:
U. S. Naval Hospital, Bethesda, Maryland
How long in hospital or institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D. C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1810 11th Street, Northwest
(If rural, give LOCATION)
2.(a) If veteran, name war: World War II

3.(a) FULL NAME: BEVERLY, Thomas Christofer, Jr.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	Negro	single

6.(b) Name of husband or wife: none
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 2 September 1921

8. AGE: Years	Months	Days	If less than one day
25	8	23	hrs. min.

9. Birthplace: Washington, D. C. (Town, county, and state)
10. Usual occupation: Clerk (Civil Service)
11. Industry or business: Department of Labor

FATHER
12. Name: Thomas Beverly
13. Birthplace: Virginia

MOTHER
14. Maiden name: Elsie Jackson
15. Birthplace: Virginia

16. Informant: Mo: Mrs. Elsie Jackson
Address: 1810 11th Street, NW, Wash., D. C.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 5-28-47 (month) (day) (year)
Cemetery or crematory: Arlington National Cemetery
Location: Arlington, Virginia

18. Funeral director: W. Ernest Jarvis
Address: 1432 U Street, NW, Washington, D. C.

19. 5-27 19 47 (Date rec'd by registrar) mary charlotte smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 25 May 19 47 at 12:12 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5-23- 19 47, to 5-25- 19 47 and that I last saw him alive on 5-25- 19 47

Immediate cause of death	DURATION
Pulmonary Edema	
Due to: Uremia	
Due to: Lower nephron nephrosis from acute hemolytic anemia	
Other conditions: Drug sensitivity - sulfa	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results: Hemolytic anemia, pulmonary edema and lower nephron nephrosis
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Jack D. Wycoff J. D. WYCOFF, Lt. (jg) (MC) USNR M. D. or other
Address: USNH, Bethesda, Md. Date signed:

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 6/1/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93e

04145

CERTIFICATE OF DEATH

Reg. Dist. No. 217

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County Mont. County.
City or town near Olney
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 days
Hospital, institution, or street address (where death occurred):
Mont. Co. Gen. Hospital
How long in hospital or institution? 6 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Mont.
City or town Sandy Spring
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Matilda Brown

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Negro	Widowed

6.(b) Name of husband or wife Melvin Brown
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) unknown

8. AGE: Years: Over 90 | Months | Days | If less than one day: ..... hrs. ..... min.

9. Birthplace unknown (Town, county, and state)
10. Usual occupation domestic
11. Industry or business Home
FATHER 12. Name unknown
13. Birthplace
MOTHER 14. Maiden name unknown
15. Birthplace
16. Informant Hospital records
Address — Olney, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof May 28, 1947 (month) (day) (year)
Cemetery or crematory Church Cemetery
Location Sandy Spring, Md
18. Funeral director R. L. Stonebraker
Address Rockville, Md.
19. May 28 1947 (Date rec'd by registrar) Gertrude B. Lauder Registrar

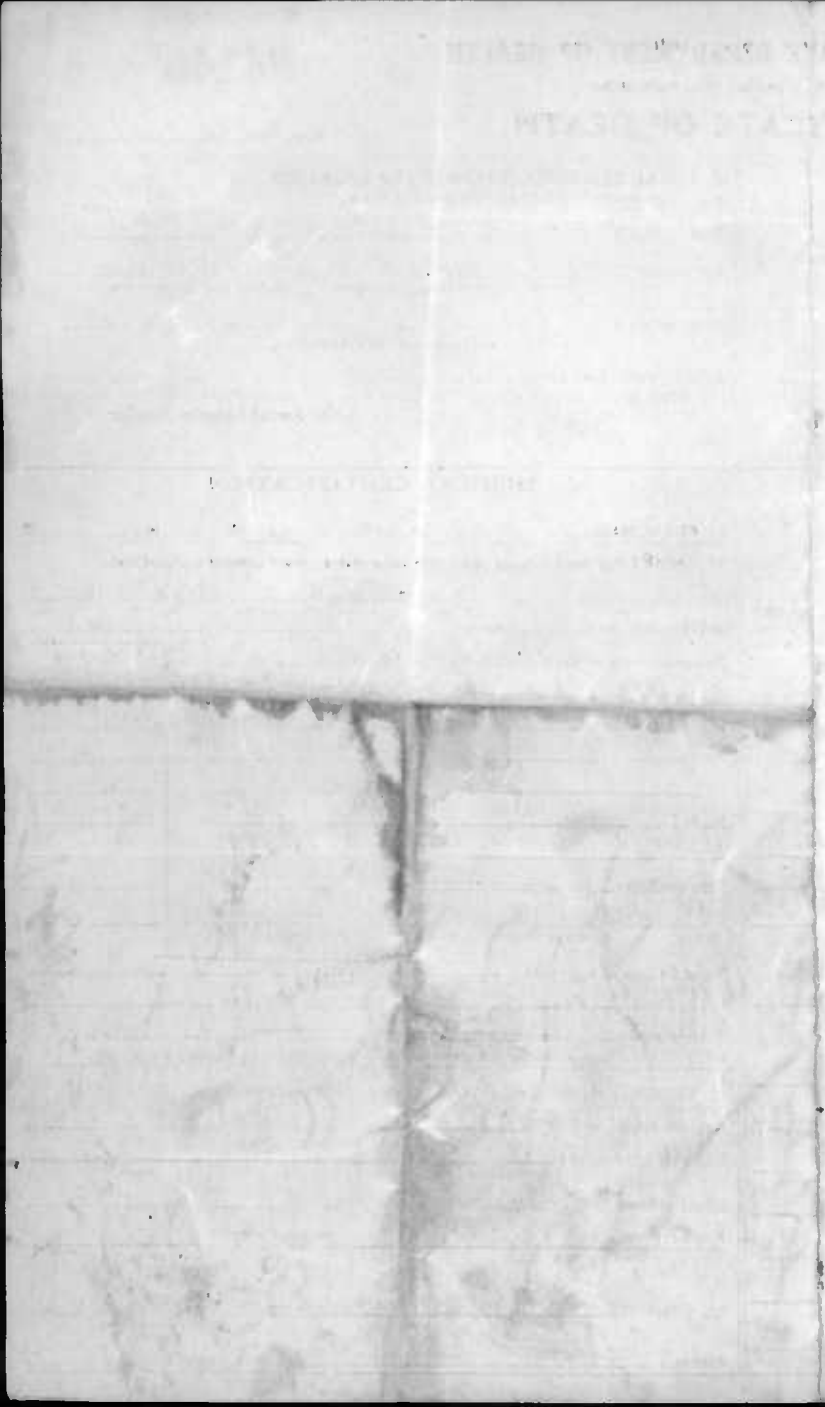
MEDICAL CERTIFICATION

20. DATE OF DEATH May 25 1947 at 11:30 a. M.
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 5-18 1947, to 5-25 1947
and that I last saw h.. alive on 5-24 1947
Immediate cause of death Broncho Pneumonia — 6 days
With Myocarditis — Unknown
Due to
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

DURATION

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Charles Emerson M. D. or
Address Sandy Spring Md Date signed May 29 1947



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

64148

(117-6)

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 day

Hospital, institution, or street address where death occurred:

US Naval Hospital, Bethesda, Md.

How long in hospital or institution? 1day

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: D.C. County:

City or town: Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1312 Rhode Island Avenue, N.W.

(If rural, give LOCATION)

2.(a) If veteran, name war: 2nd WW

3.(a) FULL NAME: BROWN, Paul

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	Col.	married

6.(b) Name of husband or wife: Annie Bell Brown

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): December 13, 1909

8. AGE: Years	Months	Days	If less than one day
37	5	12	hrs. min.

9. Birthplace: Georgia (Town, county, and state)

10. Usual occupation: Painter

11. Industry or business:

FATHER — 12. Name: Brown, Sam dec.

13. Birthplace: Ga.

MOTHER — 14. Maiden name: Mattie ? dec.

15. Birthplace: ?

16. Informant: Wife: Mrs. Annie B. Brown

Address: 1312 Rhode Island Ave., N.W., Wash., D.C.

17. burial (Burial, cremation, or removal. Which?) Date thereof: 5-29-47 (month) (day) (year)

Cemetery or crematory:

Location: Palatka, Florida

18. Funeral director: W. Ernest Jarvis

Address: 1132 U St., N.W., Wash., D.C.

19. May 26 1947 Mary Charlotte Smith (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 25 May 1947, at 10:45A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 24 May 1947 to 25 May 1947 and that I last saw him alive on 25 May 1947

Immediate cause of death	DURATION
Peritonitis	
Due to: Perforated duodenal ulcer	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results: Confirmed above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: J. D. WYCOFF, Lt.(jg)(MC) USNR (M. D. or other)

Address: USNH Bethesda, Md. Date signed: 5-26-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

6/2/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

186a C4149

CERTIFICATE OF DEATH

Reg. Diat. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 mo. 6 days

Hospital, institution, or street address where death occurred:

U. S. Naval Hospital, Bethesda, Md.

How long in hospital or institution? 1 mo. 6 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Calvert

City or town: Prince Frederick

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Calvert County Hospital

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: CASSARD, Edith Dowell

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	married

6.(b) Name of husband or wife: Capt. W. G. Cassard, dec.

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): April 1861

8. AGE: Years	Months	Days	If less than one day
86	1	- -	..... hrs. ..... min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER — 12. Name: William Dowell

13. Birthplace: Prince Frederick, Md.

MOTHER — 14. Maiden name: Mary Shemwell

15. Birthplace: Prince Frederick, Md.

16. Informant: Capt. Paul Cassard, USN

Address: Ontario Apts., 2853 Ontario Rd. Wash. D.C.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 5-28-47 (month) (day) (year)

Cemetery or crematory: St. Paul's Church Cemetery

Location: Prince Frederick, Calvert, Maryland

18. Funeral director: Robert Harkness R.A.M.

Address: Prince Frederick, Maryland, D. C.

19. 5-24 1947 (Date rec'd by registrar) Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 24 May 1947, at 12:00 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4-18 1947, to 5-24- 1947 and that I last saw h...er alive on 5-24- 1947

Immediate cause of death	DURATION
Nephritis, Chronic	
Due to: Congestive Heart Failure	
Due to: Fracture, Simple, left femoral neck	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: J.P. Platt J.P. PLATT, LT MC USN (M. D. or other)

Address: USNH, Bethesda, Md. Date signed:

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

6/2/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

462

CERTIFICATE OF DEATH

Reg. Dist. No. 4112/7

1. PLACE OF DEATH:
County: Brookeville Mont Co. Md
City or town: "
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Brookeville
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3.(a) FULL NAME: Mrs. Annie E. Cecil

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Wilbur E. Cecil
6.(c) If alive, give age: 75 years

7. Birth date of deceased (mo., day, yr.): August 3, 1869

8. AGE:

Years	Months	Days	If less than one day
77	9	16	..... hrs. ..... min.

9. Birthplace: Frederick County, Maryland.
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business

FATHER
12. Name: W. T. Sears.
13. Birthplace: Frederick County, Md.

MOTHER
14. Maiden name: Sarah Nichols
15. Birthplace: Frederick County, Md.

16. Informant: Mr. W. E. Cecil
Address: Brookeville, Maryland.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5/22/47 (month) (day) (year)
Cemetery or crematory: Mount Olivet Cemetery
Location: Frederick, Maryland
18. Funeral director: M. A. Eichnicker and Son
Address: Frederick, Maryland

19. May 19 1947 (Date rec'd by registrar) Estelle B. Lawson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 19 1947, at 12 00 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 19 1947, to May 19 1947
and that I last saw her alive on May 19 1947

Immediate cause of death	DURATION
Carcinoma of bowels	unknown
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: no
Date of op.
Autopsy results: no
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Chas B Tunnelson M. D. or other
Address: Magog Sandy Spring Md Date signed: 5-24-47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

F 516

64150 Reg. Dist. No. 223

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Takoma Park, Mont.

City or town: Maryland Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Washington Sanitarium Hosp.

How long in hospital or institution? Deceased

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Virginia County: Arlington

City or town: Arlington, Va.

(If outside city or town limits, write RURAL and give nearest town)

Street No. 4416 N. 4th Rd.

(If rural, give LOCATION)

2.(a) If veteran, name war: none

3. (a) FULL NAME: Howard D. Clapp

3. (b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	married

6.(b) Name of husband or wife: Mrs. Nettie L. Clapp

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Aug. 12, 1878

8. AGE:

Years	Months	Days	If less than one day
68			..... hrs. ..... min.

9. Birthplace: North Hampton Mass. (Town, county, and state)

10. Usual occupation: Retired

11. Industry or business

FATHER

12. Name: Henry S. Clapp

13. Birthplace: N. Hampton Mass.

MOTHER

14. Maiden name: Clara Clark

15. Birthplace: N. Hampton, Mass.

16. Informant: Nettie L. Clapp

Address: 4416 N. 4th Rd, Apt 1 Arlington

17. Removal (Burial, cremation, or removal. Which?) Date thereof 5-12-47 (month) (day) (year)

Cemetery or crematory

Location: Washington DC.

18. Funeral director: J. William Lee's Sons Co

Address: 300-4th St NE Washington DC

19. May 14 1947 (Date rec'd by registrar) J. Holton Deal Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 12th 1947, at 6:00 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 27 1937, to May 12th 1947

and that I last saw him alive on May 9th 1947

Immediate cause of death	DURATION
Prostatic carcinoma	
Due to	
Due to	
Other conditions: Metastases	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ..... Injured at work?

23. SIGNATURE: Henry J. Hadley M. D. Other

Address: 6th St SW Wash DC Date signed: May 13th 1947

56.57 6th St N Auto VC

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 179-D

CERTIFICATE OF DEATH

Reg. Dist. No. 2223- C4151

1. PLACE OF DEATH:

County Montgomery

City or town Takoma Park
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 hours

Hospital, institution, or street address where death occurred:
Washington Sanitarium

How long in hospital or institution? 7 hours

2. USUAL RESIDENCE (HOME) OF DECEASED: P. Co.
(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Mt. Ranier
(If outside city or town limits, write RURAL and give nearest town)

Street No. 2802 Upshur St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Mrs Myrtle Cooper

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife Levin E. Cooper

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Sept. 3, 1893

8. AGE: Years 53 | Months 8 | Days 16 | If less than one day ..... hrs. ..... min.

9. Birthplace Knoxville, Md.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name Robert Keller
13. Birthplace Knoxville Md.

MOTHER
14. Maiden name Cora Weisker
15. Birthplace Knoxville Md.

16. Informant Sanitarium Records.
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 23-1947 (month) (day) (year)

Cemetery or crematory Reform Cemetery

Location Brunswick, Md.

18. Funeral director The L. V. Hines Co.

Address 2901-14th St. N.W. Wash. 9, D.C.

19. May 19 1947 (Date rec'd by registrar) J. Elton Dodd Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 19 1947, at 1:55 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 1946 to May 19 1947

and that I last saw h alive on May 19 1947

Immediate cause of death	DURATION
Bronchial Pneumonia	13 hrs.
Due to Coronary Thrombosis	
Due to	
Other conditions Taken take by mouth	

(Include pregnancy within 3 months of death)

Major findings of operation

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accidental Date of 5-19-47

Where did injury occur? Mt. Ranier (City or town) Prince Georges (County) Md. (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Frank J. Bouchant M.D. M. D. or other

Address Gaithersburg Md. Date signed 5-19-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 940

CERTIFICATE OF DEATH

04152 Reg. Dist. No. 223

1. PLACE OF DEATH:
County: Montgomery
City or town: Takoma Park
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: 805 Maple Ave.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D. C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 1435 N St., N. W.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: MRS. VICTORIA MAGDALENE COWAN

3.(b) Social Security Number:

4. Sex: female
5. Color or race: white
6.(a) Single, married, widowed, or divorced: widowed
6.(b) Name of husband or wife: Edward
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.): Sept. 20th. 1865

8. AGE: Years	Months	Days	If less than one day
81	7	11	hrs. min.

9. Birthplace: McEwen, Tenn.
(Town, county, and state)
10. Usual occupation: Retired
11. Industry or business

FATHER
12. Name: Roberson Garrett
13. Birthplace: Tenn.

MOTHER
14. Maiden name: Magdelene Bibb
15. Birthplace: Tenn.

16. Informant: Mr. R. H. Cowan
Address: 1444 N St. N.W. Wash. D.C.

17. Removal & Burial Date thereof 5-3-1947
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory
Location: McEwan, Tenn.

18. Funeral director: Warner E Pumphrey
Address: Silver Spring, Md.

19. May 2 1947 J. Hiram Dodd
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 1 1947, at 1:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dep Med Exam 19... to ... 19...
and that I last saw h... alive on Case 19...

Immediate cause of death: Coronary occlusion — DURATION: died suddenly

Due to
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ... Injured at work?

23. SIGNATURE: Frank J. Broschart M.D. Dep Med Exam
M. D. or other
Address: Gaithersburg Md Date signed 5-1-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

932

C4153

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 weeks, 6 days

Hospital, institution, or street address where death occurred:

Suburban Hospital

How long in hospital or institution? 3 weeks, 6 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: MARYLAND County: MONTGOMERY

City or town: FOREST GLEN.

(If outside city or town limits, write RURAL and give nearest town)

Street No.: ROSENSTEEL AVE

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Mr. John T. Culver

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	SINGLE

6.(b) Name of husband or wife:

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Nov. 14, 1889

8. AGE:

Years	Months	Days	If less than one day
57	6	4	..... hrs. ..... min.

9. Birthplace: Montgomery Co., Md.

(Town, county, and state)

10. Usual occupation: Assessor

11. Industry or business: Montg. Co. Md.

FATHER

12. Name: George H. Culver

13. Birthplace: Montgomery Co., Md.

MOTHER

14. Maiden name: Caroline D Graf

15. Birthplace: Md.,

16. Informant: Mrs Caroline D Culver

Address: Forest Glen - Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 21 - 1947 (month) (day) (year)

Cemetery or ~~crematory~~: St Johns

Location: Forest Glen - Montg Co - Md

18. Funeral director: Owen S Pumphrey.

Address: Silver Spring - Md

19. 5/21/47 (Date rec'd by registrar) Wm E Jobes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 18, 1947, at 11:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7 April 1947 to 18 May 1947 and that I last saw h.im alive on 17 May 1947

Immediate cause of death	DURATION
Pulmonary Embolism with infarction.	
Due to: Congestive Heart Failure.	
Due to: Arteriosclerotic Heart disease and Hypertension.	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Manning H. Alden M.D. M. D. or other

Address: 8004 Newell Court, S. S. Md. Date signed: 19 May 1947

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct name is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

77c

04154

Reg. Dist. No. 7-14

1. PLACE OF DEATH:

County: Montgomery

City or town: Silver Spring

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? ½ day

Hospital, institution, or street address where death occurred: Cedarcroft Sanitarium

How long in hospital or institution? ½ day

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Virginia County:

City or town: Alexandria

(If outside city or town limits, write RURAL and give nearest town)

Street No. 812 S. Pitt St

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Robert G. Dedmon

3.(b) Social Security Number: 578-05-2143

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	divorced

6.(b) Name of husband or wife: ex-wife Hilda Delano Dedmon

6.(c) If alive, give age: 49 years

7. Birth date of deceased (mo., day, yr.): May 27, 1901

8. AGE: Years	Months	Days	If less than one day
45	11	13	..... hrs. ..... min.

9. Birthplace: Chase City, Mecklenburg Co., Va.

(Town, county, and state)

10. Usual occupation:

11. Industry or business: Truck rental

FATHER — 12. Name: Robert Sidney Dedmon

13. Birthplace: Chase City, Va.

MOTHER — 14. Maiden name: Lelia Richards

15. Birthplace: Chase City, Va.

16. Informant: Mrs. Rebecca Edwards, sister

Address: 4 Edgewood Terrace, Alex., Va.

17. Removal (Burial, cremation, or removal. Which?) Date thereof May 10, 1947 (month) (day) (year)

Cemetery or crematory: Alexandria, Va.

Location:

18. Funeral director: Wagner E. Pumphrey

Address: Silver Spring, Md.

19. May 10 1947 (Date rec'd by registrar) Josephine McCharles Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 10 1947 at 2:10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dep. Med. Exam. 19..., to ..... 19.....

and that I last saw h... alive on Dep. Med. Exam case 19.....

Immediate cause of death	DURATION
Cerebral edema	
Due to: acute alcoholism	1 day
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Frank J. Brockett, Dep. Med. Exam., M. D. or other

Address: Gaithersburg, Md. Date signed: 5-10-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A-15 9-45-15M

10039

04155

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

61

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Suburban Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Kensington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 23 W. Baltimore St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Mrs. Henrietta Drew

3.(b) Social Security Number:

4. Sex: Female
5. Color or race: white
6.(a) Single, married, widowed, or divorced: widow
6.(b) Name of husband or wife: Henry
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.): Feb. 8, 1872
8. AGE: Years: 75 Months: 2 Days: 24 If less than one day: hrs. min.
9. Birthplace: Kingston, Mass. (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business

FATHER
12. Name: Samuel P. Cole
13. Birthplace: Mass.

MOTHER
14. Maiden name: Sarah Cook
15. Birthplace: Mass

16. Informant: Mrs. Eleanor B. Hooper (Daughter)
Address: same

17. CREMATION (Burial, cremation, or removal. Which?) Date thereof MAY-5-1947 (month) (day) (year)
Cemetery or crematory: Cedar Hill
Location: Suitland - Prince Georges Co. Md.
18. Funeral director: Waters & Pumphrey
Address: Silver Spring - Md.

19. 6/3 1947 (Date rec'd by registrar) Wm E Jobes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 2, 1947 at 6.25 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 21 1946 to May 2 1947 and that I last saw her alive on May 2 1947

	DURATION
Immediate cause of death: Cerebral hemorrhage	2½ days
Due to: Cardio-vascular-renal disease with hypertension	over 20 yrs.
Due to:	
Other conditions: Diabetes Mellitus	5 years

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results: see above
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Katharine D. Chapman M.D.
M. D. or other
Address: 29 West Baltimore St. Kensington, Md. Date signed: 5/2/47

M

1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

04156
216
Reg. Diat. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Montgomery
City or town: Chevy Chase (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 34yrs
Hospital, Institution, or street address where death occurred:
6301 Brookville Road,
How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Chevy Chase (If outside city or town limits, write RURAL and give nearest town)
Street No. 6301 Brookville Road, (If rural, give LOCATION)
2.(a) If veteran, name war: None

3.(a) FULL NAME: ESCH, FRED HENRY

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Harriette H. Esch
6.(c) If alive, give age: 53 years

7. Birth date of deceased (mo., day, yr.): May 16, 1885

8. AGE: Years	Months	Days	If less than one day
62 62	0	8	— hrs. — min.

9. Birthplace: Wisconsin (Town, county, and state)
10. Usual occupation: Lawyer - retired
11. Industry or business: Law
FATHER 12. Name: Fred Esch
FATHER 13. Birthplace: Wisconsin
MOTHER 14. Maiden name: Clara Wolters
MOTHER 15. Birthplace: Wisconsin
16. Informant: Harriette H. Esch (wife)
Address: Chevy Chase, Maryland
17. Cremation (Burial, cremation, or removal. Which?) Date thereof: May 24, 1947 (month) (day) (year)
Cemetery or crematory: Cedar Hill Crematory
Location: Washington, D. C.
18. Funeral director: Wm. Reardon Humphreys
Address: Bethesda 14, Maryland
19. 5/24/1947 (Date rec'd by registrar) Wm E Jolleo Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 24/May 1947, at 4-45A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1928 19__, to 24/May 1947 and that I last saw him alive on 24/May/1947

Immediate cause of death	DURATION
Myocardial infarction	
Due to: Coronary artery Disease	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: None Date of op.
Autopsy results: None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Charles R. L. Halley MD M. D. or other
Address: 1801 Eye St. N.W. Date signed: 24 May/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

C4157

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH:
County: Montgomery
City or town: Silver Spring (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 29 yrs.
Hospital, institution, or street address where death occurred: 703 Sligo Ave.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Silver Spring (If outside city or town limits, write RURAL and give nearest town)
Street No. 703 Sligo Ave. (If rural, give LOCATION)
2.(a) If veteran, name war: No

3. (a) FULL NAME: William Chester Folsom

3. (b) Social Security Number: 578-28-7166

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Bessie Margurite
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 3rd. 1874

8. AGE: Years	Months	Days	If less than one day
72	10	13	hrs. min.

9. Birthplace: Des Moines Iowa. (Town, county, and state)
10. Usual occupation: Engineer
11. Industry or business

FATHER
12. Name: Isaac Y. Folsom
13. Birthplace: Essex Co., N. Y.

MOTHER
14. Maiden name: Mary Sackett
15. Birthplace: Unknown

16. Informant: Mrs. Bessie M. Folsom
Address: 703 Sligo Ave. Silver Spring

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5-19-1947 (month) (day) (year)
Cemetery or ~~Crematory~~: Glenwood, Wash. D. C.
Location: Washington, D. C.
18. Funeral director: Wones & Pumphrey
Address: Silver Spring, Md.

19. May 16 1947 (Date rec'd by registrar) Josephine McSchaffer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 16 1947, at 3.35 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ~~May~~ April 8 1947, to May 16 1947 and that I last saw h...im alive on May 16 1947

Immediate cause of death	DURATION
Probable Coronary Occlusion	3 hrs.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results: None.
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: H. F. McGrell M.D. M. D. or other
Address: Silver Spring, Md. Date signed 5/16/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS/A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

137a 04158

Reg. Diat. No. 223

1. PLACE OF DEATH:

County: Montgomery

City or town: Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 18 days

Hospital, institution, or street address where death occurred: Washington San. & Hosp. Takoma PK

How long in hospital or institution? 18 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No. 3701 39th St. N.W.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Mortimer Foster

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	married

6.(b) Name of husband or wife: Neonilla Foster 6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Aug. 2, 1874

8. AGE: Years: 72 Months: 9 Days: 16 If less than one day: hrs. min.

9. Birthplace: England (Town, county, and state)

10. Usual occupation: Architect

11. Industry or business: Building

FATHER

12. Name: Amos Foster

13. Birthplace: England

MOTHER

14. Maiden name: Mary Ann Jackson

15. Birthplace: England

16. Informant: Mrs. Neonilla Foster

Address: 3701 39th St. N. W.

17. burial (Burial, cremation, or removal. Which?) Date thereof 5/20/47 (month) (day) (year)

Cemetery or crematory: Maple Grove Cemetery

Location: Kew Gardens, New York

18. Funeral director: Z. & H. Hines Co.

Address: 2901-14th St. N.W.

19. 5/19/47 (Date rec'd by registrar) William Dodd Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 18 19 47 at 7:35 P. M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from April 27 19 47, to May 18 19 47

and that I last saw him alive on May 18 19 47

Immediate cause of death	DURATION
Uremia	est. 6 months
Due to: Hydronephrosis, Chronic	unknown
Due to: prostatic hypertrophy	unknown
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Russell A. Dunn M.D.

M. D. or other

Address: Washington San. & Hosp. Date signed: May 18, 1947

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Evidence for the change of birth date range shown on S.S.A. - 7/7/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

108 CB 04159

Reg. Diat. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 month

Hospital, Institution, or street address where death occurred:
U. S. Naval Hospital, Bethesda, Md.

How long in hospital or institution? 2 month

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 3754 Kanawha Street, Northwest
(If rural, give LOCATION)

2.(a) If veteran, name war: WW I

3. (a) FULL NAME: FRANKLAND, Walter Ashby (Ashby)

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Mrs. Alice P. Frankland

6.(c) If alive, give age: 81 years

7. Birth date of deceased (mo., day, yr.): 10 December ~~1868~~ 1867

8. AGE: Years 79 Months 5 Days 20 If less than one day ..... hrs. ..... min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: Medical Officer, Retired

11. Industry or business: U. S. Public Health Service

FATHER 12. Name: Walter Frankland

13. Birthplace: Virginia, dec.

MOTHER 14. Maiden name: Alice Williams

15. Birthplace: Ohio, dec.

16. Informant: Wife: Mrs. Alice P. Frankland

Address: 3754 Kanawha St., NW, Washington, D.C.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 6-2-47 (month) (day) (year)

Cemetery or crematory: Arlington National Cemetery

Location: Arlington, Virginia

18. Funeral director: W. W. Chambers Co. C Beason

Address: 3072 M Street, NW, Washington, D. C.

19. (Date rec'd by registrar) May 30 1947 Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 30 May 1947, at 3:11 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3-31 1947, to 5-30 1947 and that I last saw him alive on 5-30- 1947

Immediate cause of death	DURATION
Lobar pneumonia, both lower lobes (terminal)	10 days
Due to Generalized arteriosclerosis	10 yrs.
Due to Hunt. Chorea.	15 yrs.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results: Cx as noted above.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: R. N. GRANT, CDR MC USN
M. D. or other

Address: U. S. Naval Hospital, Bethesda, Md. Date signed: 5-30-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

4/10/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

MARGIN RESERVED FOR BINDING

VS A15 9.45.15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 157 b

04160

CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH:
County Montgomery
City or town Olney (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 21 days
Hospital, institution, or street address where death occurred: Montgomery Co Gen Hosp
How long in hospital or institution? 22 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Silver Spring (If outside city or town limits, write RURAL and give nearest town)
Street No. 709 Sligo Ave. (If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Delores Rae Golden

3. (b) Social Security Number none

4. Sex F.
5. Color or race N
6.(a) Single, married, widowed, or divorced Baby
6.(b) Name of husband or wife —
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.) 4/15/47

8. AGE: Years — Months — Days 22 — If less than one day ... hrs. ... min.

9. Birthplace Olney Mont Co. Md (Town, county, and state)
10. Usual occupation —
11. Industry or business —

FATHER
12. Name Arless Golden
13. Birthplace N.C.

MOTHER
14. Maiden name Emma Clark.
15. Birthplace Md.

16. Informant Mother.
Address 709 Sligo Ave. Silver Spring

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 9 1947 (month) (day) (year)
Cemetery ~~or crematory~~ George Washington Memorial
Location Riggs Rd Extended Pr Georges Co. Md

18. Funeral director Warner E Pumphrey.
Address Silver Spring - Md -

19. May 7 1947 (Date rec'd by registrar) Gertrude B. Fowler Registrar

Permit issued at Silver Spring, Md

MEDICAL CERTIFICATION

20. DATE OF DEATH ~~[illegible]~~ May 7th 1947 at 8:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4/15/ 1947 to 5/7/ 1947 and that I last saw her alive on 5/7/ 1947

	DURATION
Immediate cause of death: Meningitis.	3 days
Due to: Infection - mixed, possibly staphylococcus	[5/30/47 [illegible]]
Due to: Spina Bifida	22 days
Other conditions: Clubfeet	22 days

(Include pregnancy within 3 months of death)

Major findings of operations None.
Date of op.
Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work? —

23. SIGNATURE J. M. Bird M. D. ~~or other~~
Address Sandy Spring Date signed 5/7/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

170a

#2

C4161

Reg. Dist. No. 216

1. PLACE OF DEATH:
County Montgomery
City or town Bethesda
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? sudden death
Hospital, institution, or street address where death occurred:
Dorset Ave. Railroad crossing
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State County
City or town Washington, D. C.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 810 4th St. N. W.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Mrs. Shirley Yates Gordon

3.(b) Social Security Number 579-22-2679

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Married

6.(b) Name of husband or wife Evans Gordon
6.(c) If alive, give age 28 years
7. Birth date of deceased (mo., day, yr.) Nov. 23, 1922

8. AGE: Years	Months	Days	If less than one day
24	5	21	hrs. min.

9. Birthplace Washington, D. C.
(Town, county, and state)
10. Usual occupation Maid
11. Industry or business

FATHER
12. Name Henry Yates
13. Birthplace Virginia

MOTHER
14. Maiden name Mamie Carter
15. Birthplace Richmond, Va.

16. Informant Mrs. Bernice Yates
Address Mother-same above

17. Removal (Burial, cremation, or removal. Which?) Date thereof 5/15/47 (month) (day) (year)
Cemetery or crematory Washington, D. C.
Location
18. Funeral director Stewart Funeral Home
Address 30th H. St. N. E.

19. 5/15 19 47 (Date rec'd by registrar) Wm E Jones Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 14, 19 47, at 4:30P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Dep. Med. Exam. Case	
Internal Hemorrhage	Died
Due to crushed chest and back.	sudden
(accident)	
Due to	
Other conditions	
M V Coma [illegible]	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide accident Date of 5/14/47
Where did injury occur? Bethesda, Montgomery, Md.
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?) Public road
Means of injury Railroad crossing Injured at work? No

23. SIGNATURE Frank J Bronhad Dep. Med. Exam. M. D. or other
Address Gaithersburg, Md. Date signed 5/14/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

92d 04162

Reg. Dist. No. 213

1. PLACE OF DEATH:

County: Montgomery

City or town: Hunting Hill MD Rural
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Suddenly

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Rural Potomac MD.
(If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION) No

2.(a) If veteran, name war

3.(a) FULL NAME: Louis J. Gray

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Nellie Gray

6.(c) If alive, give age: 62. years

7. Birth date of deceased (mo., day, yr.): Nov. 27 1879

8. AGE: Years	Months	Days	If less than one day
67	5	9	....hrs. ....min.

9. Birthplace: Lowden CO. VA.
(Town, county, and state)

10. Usual occupation: none

11. Industry or business: none

FATHER
12. Name: Steven Ellis
13. Birthplace: VA.

MOTHER
14. Maiden name: Marrah Galb
15. Birthplace: VA.

16. Informant: Nellie Grey
Address: Potomac MD.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 9. 1947 (month) (day) (year)

Cemetery or crematory: Laytonsville, MD.

Location: Montgomery CO. MD.

18. Funeral director: Roy W. Barber

Address: Laytonsville, MD.

19. May 8 1947 (Date rec'd by registrar) E. P. [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 6 1947, at 5.30 M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Feb. 2 1947, to May 6 1947 and that I last saw him alive on April 30 1947

Immediate cause of death	DURATION
acute dilatation of heart,	suddenly
Due to Chronic mitral regurgitation	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ....Date of op. ....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ....Date of ....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: E. O. Hartley M.D. M. D. or other

Address: Rockville, Md. Date signed 5/8/1947

VS-A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

61

04163

Reg. Dist. No. 247

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County Montgomery

City or town Olney, Maryland.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
The Montgomery County General Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Gaithersburg
(If outside city or town limits, write RURAL and give nearest town)

Street No. R. #1 Woodfield
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Mrs. Mary E. Green

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed.

6.(b) Name of husband or wife Elmer Green

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) December 27, 1898

8. AGE: Years 48 | Months 4 | Days 15 | If less than one day hrs. min.

9. Birthplace Woodfield, Maryland.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business —

FATHER 12. Name David Ward

13. Birthplace Middlebrook, Md.

MOTHER 14. Maiden name Hedelia Woodfield

15. Birthplace Woodfield, Md.

16. Informant Hospital records

Address —

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 15, 1947 (month) (day) (year)

Cemetery or crematory Werby Frederick Md

Location Woodfield Md

16. Funeral director Roy W. Barber

Address Ijamsville Md

19. May 14 1947 Gertrude R. Lawler
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 12 1947, at 4:02 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1947, to May 12 1947

and that I last saw h. alive on May 12 1947

Immediate cause of death	DURATION
Coronary occlusion	12 hrs
Due to Hypertension chronic interstitial nephritis	10 yrs
Due to	
Other conditions Diabetes	13 yrs

(Include pregnancy within 3 months of death)

Major findings of operations None

Date of op. —

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —

Where did injury occur? — — —
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work?

23. SIGNATURE J. W. B.
M. D. or other

Address Sandy Spring, Md. Date signed 5/12/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

170a

CERTIFICATE OF DEATH

04164

Reg. Dist. No. 216

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Sudden death
Hospital, institution, or street address where death occurred:
Dorset Ave. railroad crossing.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: County:
City or town: Washington, D. C.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2325 N. Street, N. W. Apt. A
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Jeff C. Handy

3.(b) Social Security Number: 222-10-2009

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife: Genevieve Grahant
6.(c) If alive, give age: 42 years

7. Birth date of deceased (mo., day, yr.): May 28, 1905

8. AGE: Years	Months	Days	If less than one day
42	11	16	hrs. min.

9. Birthplace: Daver, Del. (Town, county, and state)
10. Usual occupation: Houseman, Congressional Country Club
11. Industry or business:

FATHER
12. Name: Parker Handy
13. Birthplace: Unknown

MOTHER
14. Maiden name: Rebecca Handy
15. Birthplace: Unknown

16. Informant: Genevieve G. Handy
Address: Wife, above address

17. Removal (Burial, cremation, or removal. Which?) Date thereof 5/14/47 (month) (day) (year)
Cemetery or crematory: Washington, D. C.
Location:

18. Funeral director: Ernest W. Jarvis Co.
Address: 1432 U. Street, N.W. D.C.

19. 5/14 19 47 (Date rec'd by registrar) Wm E Forbes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 14, 1947, at 4:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Dep. Med. Exam. Case	
Inter-thorasic hemorrhage	died
Due to crushed chest.	suddenly
Due to (accident)	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of: 5/14/47
Where did injury occur? Bethesda, Montgomery, Md. (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): Public road
Means of injury: Railroad crossing Injured at work? No

23. SIGNATURE: Frank J. Broschart M.D. Dep. Med. Exam. M. D. or other
Address: Gaithersburg, Md. Date signed: 5/14/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

04165

CERTIFICATE OF DEATH

Reg. Dist. No. 223-

1. PLACE OF DEATH:

County: Montgomery

City or town: Takoma Park md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 yrs

Hospital, institution, or street address where death occurred:

505 Carroll ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

Street No. 505 Carroll ave

(If rural, give LOCATION)

2.(a) If veteran, name war: 1917 Army 38 yrs

3.(a) FULL NAME Charles A. Hartley

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	married

6.(b) Name of husband or wife: Agnes C. Hartley

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Aug 1 1888

8. AGE:	Years	Months	Days	If less than one day
	58	8	22	..... hrs. ..... min.

9. Birthplace: York Pa (Town, county, and state)

10. Usual occupation: Master Sergt.

11. Industry or business: U. S. A.

FATHER — 12. Name: Lawton M. Hartley

13. Birthplace: Pa

MOTHER — 14. Maiden name: Sarah A Baylor

15. Birthplace: Pa

16. Informant: Agnes C. Hartley

Address: 505 Carroll ave Takoma Park md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 26 1947 (month) (day) (year)

Cemetery or crematory: Arlington National

Location: Arlington Co. Virginia

18. Funeral director: Elmer E Pumphrey.

Address: Silver Spring

19. 5/23 (Date rec'd by registrar) 19 47 J. Wilson Dodd Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 23 19 47, at 7:20 A.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 3rd Med. Exam 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Coronary occlusion	Sudden
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Jean J Broschart M.D. M. D. or other

Address: Gaithersburg md Date signed 5-23-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

C4166

124 b

Reg. Dist. No. 216

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 days
Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.
How long in hospital or institution? 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D.C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 1254 Queen St., N.E.
(If rural, give LOCATION)
2.(a) If veteran, name war: WW II

3.(a) FULL NAME: HENES, Ben Charles,

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	married

6.(b) Name of husband or wife: Mrs. Delma Henes
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): September 3, 1906

8. AGE: Years	Months	Days	If less than one day
40	8	2	hrs. min.

9. Birthplace: N.Y. (Town, county, and state)
10. Usual occupation: Emerson Radio, Wash., D.C.
11. Industry or business:

FATHER
12. Name: John Henes,
13. Birthplace: New York

MOTHER
14. Maiden name: Mary Enger
15. Birthplace: Austria

16. Informant: wife: Mrs. Delma Henes
Address: 1254 Queen St., N.E., Wash., D.C.

17. burial (Burial, cremation, or removal. Which?) Date thereof: 5-8-47 (month) (day) (year)
Cemetery or crematory: Arlington National
Location: Arlington, Va.

18. Funeral director: W. W. CHAMBERS F.D.
Address: 1400 Chapin St., N.W., Wash., D.C.

19. 5-5- 1947 (Date rec'd by registrar) Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 5 May 1947 at 2:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1 May 1947 to 5 May 1947 and that I last saw h... im alive on 5 May 1947

	DURATION
Immediate cause of death: Hemorrhage from esophageal varices	5 days
Due to: Cirrhosis of the liver (Portal)	unknown
Due to: Dietary deficiency associated with several	
extreme chronic alcoholism	years
Other conditions: Bilateral bronchopneu-	72 hrs.
monia	

(Include pregnancy within 3 months of death)

Major findings of operation: ...date of operation:
Autopsy results: Portal Cirrhosis, bronchopneumonia, ...
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: P. R. ENGLE, Comdr. (MC) USN
M. D. or other
Address: USNH Bethesda, Md. Date signed: 5-5-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

5/15/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

526 R 04167

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 months, 4 days

Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.

How long in hospital or institution? 2 months, 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D.C. County:

City or town: Washington,
(If outside city or town limits, write RURAL and give nearest town)

Street No. 619 L Street, N.E.
(If rural, give LOCATION)

2.(a) If veteran, name war: WWI

3.(a) FULL NAME: HOLMES, William Samuel

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	~~W~~ US	widowed

6.(b) Name of husband or wife: ~~Married~~

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 18 April 1890

8. AGE: Years	Months	Days	If less than one day
57	0	27	hrs. min.

9. Birthplace: Washington, D.C.
(Town, county, and state)

10. Usual occupation: unemployed

11. Industry or business

FATHER — 12. Name: Holmes, Samuel dec.

13. Birthplace: Va.

MOTHER — 14. Maiden name: Randolph, Elizabeth dec.

15. Birthplace: Va.

16. Informant: sister: Mrs. Marie Janifer

Address: 619 L St., N.E., Wash., D.C.

17. burial (Burial, cremation, or removal. Which?) Date thereof 5-20-47 (month) (day) (year)

Cemetery or crematory: Arlington National

Location: Arlington, Va.

18. Funeral director: W. Ernest Jarvis

Address: 1432 U St., N.W., Wash., D.C.

19. 5-15 19 47 (Date rec'd by registrar) Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 15 May 19 47, at 1:10A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 11 19 47, to May 15 19 47 and that I last saw h~~im~~ alive on 15 May 19 47

Immediate cause of death	DURATION
UREMIA	3 weeks
Due to CARCINOMA OF BLADDER & METASTASES	1 year
Due to	
Other conditions BRONCHOPNEUMONIA	1 week

(Include pregnancy within 3 months of death)

Major findings of operations: CARCINOMA OF BLADDER

Date of op. MARCH, 1947

Autopsy results: CARCINOMA OF BLADDER

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: R. E. FITZGERALD, Lt. (jg) MC USNR
M. D. or other

Address: USNH Bethesda, Md. Date signed 5-15-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

5/26/47

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1

VS-A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

C4168

932

Reg. Dist. No. 216

1. PLACE OF DEATH:
County: 4- West Melrose St.
City or town: Ch. Ch. Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Montgomery
City or town: Ch. Ch. Md
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 4- West Melrose St.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Frank Wheeler Hornbrook

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Widowed

6.(b) Name of husband or wife: Anna K. Hornbrook

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Oct 25- 1875

8. AGE: Years	Months	Days	If less than one day
71			..... hrs. ..... min.

9. Birthplace: Evansville, Ind
(Town, county, and state)

10. Usual occupation: Phy. Retired

11. Industry or business

FATHER
12. Name: Saunders R. Hornbrook
13. Birthplace: Ohio

MOTHER
14. Maiden name: Lucy Wheeler
15. Birthplace: Ind

16. Informant: Saunders R. Hornbrook
Address: 4 West Melrose Ch Ch. Md (Son

17. Removal (Burial, cremation, or removal. Which?) Date thereof 3/3/47 (month) (day) (year)
Cemetery or crematory: Glenwood Cem.
Location: Wheeling, W. Va.

18. Funeral director: The S. H. Hines Co
Address: 2901- 14 St N W

19. 3/3 1947 (Date rec'd by registrar) Wm E Jobes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 2 May 1947, at 10:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1 May 1947, to 2 May 1947 and that I last saw him alive on 2 May 1947

Immediate cause of death	DURATION
Acute Myocardial decompensation	2 wks.
Due to: Cause undetermined	
Due to:	
Other conditions: Ascites, pulmonary edema & edema legs	

(Include pregnancy within 3 months of death)

Major findings of operations: —
Date of op.: —
Autopsy results: —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: —
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Howard Sloaff, M.D. (M. D. or other)
Address: 3921 Ingoman St. Washington, D.C. Date signed: 2 May '47

Evidence for the addition of
items 4,5,6 shown on

M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (107)

04169

Reg. No. G 110 JUN 16 1947

CERTIFICATE OF DEATH

Reg. Dist. No. 216 ~~75~~

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

County Montgomery

City or town Bethesda Maryland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Since 5-12-47

Hospital, institution, or street address where death occurred: Suburban Hosp., 8600 Old Georgetown Rd., Bethesda Md.

How long in hospital or institution? Since 5-12-47

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Virginia County

City or town Stanley (If outside city or town limits, write RURAL and give nearest town)

Street No. R.R.I (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Mr Wilson Housden

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	M

6.(b) Name of ~~husband or~~ wife Rita Housden

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.) August 1, 1914

8. AGE: Years	Months	Days	If less than one day
32	8	23	... hrs. ... min.

9. Birthplace Stanley Virginia (Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

FATHER

12. Name Otis Housden

13. Birthplace Stanley Virginia

MOTHER

14. Maiden name Elsie Kibler

15. Birthplace Stanley Virginia

16. Informant

Address

17. Burial (Burial, cremation, or removal, Which?) Date thereof May 26 1947 (month) (day) (year)

Cemetery or crematory Leaksville cemetery

Location Luray

18. Funeral director J C Bradley

Address Luray Va

19. 5/24 1946 (Date rec'd by registrar) Wm E Jobes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 24 1947, at 12 35 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 17 May 1947, to 24 May 1947 and that I last saw him alive on 24 May 1947.

	DURATION
Immediate cause of death Pemphigus	1 mo.
Due to	
Due to	
Other conditions Bronchopneumonia, terminal (Include pregnancy within 3 months of death)	2 days

Major findings of operations None.

Date of op.

Autopsy results None.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Joseph J Wallace M.D. (M. D. or other)

Address 8318 16th St. Silv. Spg. Md. Date signed 24 May 47

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VS A15

C4170

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

CERTIFICATE OF DEATH

Reg. Diat. No. 716

1. PLACE OF DEATH

County Montgomery

City or town Bethesda
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: Suburban Hospital

How long in hospital or institution? 13 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Couoty

City or town Washington D C
(If outside city or town limits, write RURAL and give nearest town)

Street No. 413 Butternut St. N.W.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Mrs - Beulah C. Jenkins

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	divorced

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 13, 1891

8. AGE: Years 55 | Months 11 | Days 18 | If less than one day ... hrs. ... min.

9. Birthplace Rayne City, Texas
(Town, county, and state)

10. Usual occupation Govt clerk

11. Industry or business

FATHER 12. Name William Cockerell

13. Birthplace Texas

MOTHER 14. Maiden name Mary Scott

15. Birthplace Mississippi

16. Informant Jack H. Jenkins (Son)

Address Same

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6/3/47 (month) (day) (year)

Cemetery or crematory Ft Lincoln Cem

Location

18. Funeral director S H Hines Co.

Address 2901-14th St NW

19. 5/31 (Date rec'd by registrar) 1947 Wm E Jones Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 31, 1947 at 4:45 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4-1-47 to 5-31 1947 and that I last saw h.e.r alive on 5-31-47

	DURATION
Immediate cause of death: Coronary Occlusion	14 days
Due to: Coronary Arteriosclerosis	2 yrs
Due to:	
Other conditions: Arteriosclerosis, genral	5 yrs
Hypertension	5 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE Andrew J Beh M D M. D. or other

Address 800 Butternut St Date signed 5-31-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct title is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

04171

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 month 3 days

Hospital, institution, or street address where death occurred:

USNH, Bethesda, Maryland

How long in hospital or institution? 1 month 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington, D. C.

(If outside city or town limits, write RURAL and give nearest town)

Street No.: U. S. Naval Magazine, Bellevue

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: JERVEY, Jean Webb

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widowed

6.(b) Name of husband or wife: unknown

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): 22 Nov. 1868

8. AGE: Years	Months	Days	If less than one day
78	5	18	..... hrs. ..... min.

9. Birthplace: New Jersey (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER — 12. Name: Edward C. Webb

13. Birthplace: New York

MOTHER — 14. Maiden name: Mary Sandford

15. Birthplace: New York

16. Informant: daughter: Mrs. Jean J. Quintard

Address: U. S. Naval Magazine, Bellevue, D.C.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 5-13-47 (month) (day) (year)

Cemetery or crematory: St. Lukes Church

Location: Powhatan County, Virginia

18. Funeral director: W. W. Chambers

Address: 3072 M. Street, NW, Wash., D. C.

19. 5-10-47 (Date rec'd by registrar) Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 10 May 1947 at 7:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7 April 1947 to 10 May 1947 and that I last saw her alive on 10 May 1947

Immediate cause of death	DURATION
Congestive Heart Failure with uremia	
Due to: Hypertensive Heart Disease	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: none performed

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: J. T. FOWLER, Jr., Cdr. (MC) USN

M. D. or other

Address: USNH Bethesda, Md. Date signed: 5-10-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

GWS A15 9-45.15M

5/12/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1318 04211

CERTIFICATE OF DEATH

Reg. Diat. No. 414

1. PLACE OF DEATH:

County: Montgomery

City or town: Takoma Park
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? two days

Hospital, Institution, or street address where death occurred: Washington Sanitarium & Hospital

How long in hospital or institution? two days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 930 Ingraham St N. W.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME

Merrit S. Jewell

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Cauc.	Married

6.(b) Name of husband or wife: Laura Jewell

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): July 11 1890

8. AGE: Years	Months	Days	If less than one day
56	9	23	..... hrs. ..... min.

9. Birthplace: Kent Co. Maryland
(Town, county, and state)

10. Usual occupation: Taxi Driver

11. Industry or business: Own business

FATHER
12. Name: Robert F. Jewell
13. Birthplace: Kent Co. Md.

MOTHER
14. Maiden name: Hattie Eads
15. Birthplace: Kent Co. Md.

16. Informant: Records - Washington San & Hos
Address: Takoma Park, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 7, 1947 (month) (day) (year)

Cemetery or crematory: Prospect Hill

Location: Washington DC

18. Funeral director: A. H. Hines Co.

Address: 2901-14th St N.W.

19. May 5 19 47 (Date rec'd by registrar) Josephine M. Schaeffer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 4 19 47 at 5:30 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from May 2 19 47 to May 4 19 47

and that I last saw him alive on May 3 19 47

Immediate cause of death	DURATION (Several years)
Glomerulo nephritis	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results: Glomerulo nephritis

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: John N. Andrews M.D.

Address: Silver Spring Md. M. D. or other Date signed 5-4-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

94a

04172

Reg. Diat. No. 714

1. PLACE OF DEATH:

County Montgomery

City or town Silver Spring
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
8317 Draper Lane

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Silver Spring
(If outside city or town limits, write RURAL and give nearest town)

Street No. 8317 Draper Lane
(If rural, give LOCATION)

2.(a) If veteran, name war World War 2

3.(a) FULL NAME Vincent Raymond Judge

3.(b) Social Security Number 095-10-0403

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife Ellen

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Aug. 1st. 1910

8. AGE:	Years	Months	Days	If less than one day
	36	9	3	..... hrs. ..... min.

9. Birthplace New York City
(Town, county, and state)

10. Usual occupation Manager Shell Oil Sta.

11. Industry or business Bethesda, Md.

FATHER
12. Name Thomas Judge
13. Birthplace Ireland

MOTHER
14. Maiden name Mary Coniher
15. Birthplace Ireland

16. Informant Mr. Walter C. Brown

Address 1518 East West Hyway,

17. Removal Date thereof 5-5-1947
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory

Location New Dorp, Staten Island, N.Y.

18. Funeral director Daniel E. Pumphrey.

Address Silver Spring, Maryland.

19. May 5 1947 Josephine M. Schaeffe
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 4 1947, at 1:40 A.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Sept. 1946 1947, to May 4 1947
and that I last saw h... alive on ..... 19.....

Immediate cause of death	DURATION
Coronary occlusion	Sudden
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Frank J. Bosckert M.D. M. D. or other

Address Gaithersburg Md. Date signed 5-7-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04173

94a

Reg. Diat. No. 213

1. PLACE OF DEATH:

County Montgomery

City or town Rockville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Mont.

City or town Rockville

(If outside city or town limits, write RURAL and give nearest town)

~~Street No.~~ Groydon Pk Blvd

(If rural, give LOCATION)

2.(a) If veteran, name war No

3.(a) FULL NAME Wade H. Kendall

3.(b) Social Security Number 213-14-9136

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	WIDOWED

6.(b) Name of husband or wife HATTIE E

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) DEC-27-1883

8. AGE: Years	Months	Days	If less than one day
63	4	27	..... hrs. ..... min.

9. Birthplace Loundown Co. Va.

(Town, county, and state)

10. Usual occupation CARPENTER

11. Industry or business

FATHER

12. Name AMOS F KENDALL.

13. Birthplace VA.

MOTHER

14. Maiden name MARTHA A SKILLMAN.

15. Birthplace VA.

16. Informant MRS WILLIAM ERTTER

Address RFD 2 ROCKVILLE - MD

17. BURIAL (Burial, cremation, or removal. Which?) Date thereof MAY 27 1947 (month) (day) (year)

Cemetery ~~or crematory~~ CHESTNUT GROVE

Location HERNDON, FAIRFAX CO. VA.

18. Funeral director Warner & Pumphrey

Address Silver Spring Md

19. 5-24 1947 (Date rec'd by registrar) R Thompson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 24 1947 at 9:10 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
coronary occlusion	Dead found dead in home
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Frank J. Burchart M.D. M. D. or other

Address Gaithersburg Date signed 5-24

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Evidence for the change of year of birth is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

486 04174

FILM No. G 116 MAY 1 1947

CERTIFICATE OF DEATH

Reg. Dist. No. 716

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 hours. -
Hospital, institution, or street address where death occurred: Suburban Hospital, Bethesda, Maryland.
How long in hospital or institution? 10 hours. -

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Silver Spring
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 134 Richmond Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: MARTHA ALICE KENNEY

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: ~~William H George~~ Kenney
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): MAY 4 1859

8. AGE: Years: 88 Months: Days: If less than one day: ..... hrs. ..... min.

9. Birthplace: Cabens Spring, W. Va. (Town, county, and state)
10. Usual occupation: None
11. Industry or business:
FATHER 12. Name: Robert Miller
13. Birthplace:
MOTHER 14. Maiden name: Margaret Miller
15. Birthplace:
16. Informant: Michael J. Reedy
Address: 718 Richmond Ave Silver Spring, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 5/14/47 (month) (day) (year)
Cemetery or crematory: Hopewell Cemetery
Location: Hopewell, Virginia
18. Funeral director: Timothy Hanlon Funeral Home
Address: 641-4 St N.E. Washington, D.C.
19. 5/17/1947 (Date rec'd by registrar) Wm E Jones Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 12 May 1947 at 12:02 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 15 April 1947 to 12 May 1947
and that I last saw her alive on 11 May 1947
Immediate cause of death: Congestive Heart failure with hypertension. — DURATION
Due to: Arteriolonephrosclerosis
Due to:
Other conditions: Carcinoma of uterus.
(Include pregnancy within 3 months of death)
Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of Injury: Injured at work?

23. SIGNATURE: Manning F. Alden, M.D. M. D. or other
Address: 8004 Devell Ct. S.S. Md. Date signed: 12 May 1947.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

46e

04175

Reg. Diat. No. 714

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Montgomery

City or town: Silver Spring
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

~~How long in this city, town, or county~~ street address where death occurred:
214 Granville Drive

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Silver Spring
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 214 Granville Drive
(If rural, give LOCATION)

2.(a) If veteran, name war: no

3.(a) FULL NAME: Mrs. Ella Kieny

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widowed

6.(b) Name of husband: William E.

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Nov. 11th. 1874

8. AGE: Years	Months	Days	If less than one day
72	6	20	..... hrs. ..... min.

9. Birthplace: Virginia
(Town, county, and state)

10. Usual occupation: Retired Housewife

11. Industry or business:

FATHER
12. Name: William Mosbey
13. Birthplace: Unknown

MOTHER
14. Maiden name: Unknown Gosnell
15. Birthplace: Unknown

16. Informant: Mrs. Howard A. McCloskey

Address: 214 Granville Dr. Silver Spg.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: June 4th. 1947 (month) (day) (year)

Cemetery: Arlington National

Location: Arlington Co. Va.

18. Funeral director: Warner E. Pumphrey

Address: Silver Spring, Md.

19. June 7 1947 (Date rec'd by registrar) Josephine Schaaff Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 31, 1947, at 7 30 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Oct. 29, 1946, to May 31, 1947

and that I last saw h[er] alive on May 20, 1947

Immediate cause of death	DURATION
Toxemia	7 mos.
Due to: Carcinoma Sigmoid	
Due to:	
Other conditions: Generalized Carcinomatosis	

(Include pregnancy within 3 months of death)

Major findings of operation: Cancer of Sigmoid with metastases Date of op. Oct 29 1946

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: C. Edwin McKernan M.D.
M. D. or other

Address: 1801 Eye St. N.W. Wash. D.C. Date signed: 5/31/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

C4176

CERTIFICATE OF DEATH

Reg. Diat. No. 216

1. PLACE OF DEATH:

County Montgomery

City or town Bethesda, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Since 5-11-47

Hospital, Institution, or street address where death occurred:
Suburban Hosp. - 8600 Old Georgetown Rd.

How long in hospital or institution? Since 5-11-47 Bethesda Md.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County

City or town Kensington
(If outside city or town limits, write RURAL and give nearest town)

Street No. Saul Rd.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Anna Mrs Margaret Kline

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	

6.(b) Name of husband or wife Augustus Kline

6.(c) If alive, give age 69 years

7. Birth date of deceased (mo., day, yr.) Dec. 18, 1881

8. AGE: Years	Months	Days	If less than one day
65	5	10	....hrs. ....min.

9. Birthplace Washington D.C.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name ? Mulligan
13. Birthplace Washington D.C.

MOTHER
14. Maiden name Amelia Margaret Spates
15. Birthplace Cumberland Maryland

16. Informant Mr. Augustus M. Kline
Address Husband - Same above address

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5/31/47 (month) (day) (year)

Cemetery or crematory St. Marys Cemetery

Location Rockville, Maryland

18. Funeral director Wm Reuben Humphrey

Address Bethesda, Md.

19. 5/29 19 47 Wm E Jones
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION 10

20. DATE OF DEATH 5-28 19 47 at 11 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2d 19 47, to 28 May 19 47 and that I last saw h[illegible] alive on 27 May 19 47

Immediate cause of death	DURATION
Hemopericardium due to	
Due to Ruptured Posterior Coronary Vessel	? Minutes
Due to	
Other conditions Arteriosclerosis Generalized, Acute Coronary occlusion ?	Years

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results Hemopericardium, Coronary Thrombosis, Arteriosclerosis

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W S Humphrey M.D. M.D. or other

Address Rockville Md Date signed 28 May 47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully; the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04177

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Chevy Chase

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 9 mo

Hospital, Institution, or street address where death occurred:

20 W. Kirke St

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Chevy Chase

(If outside city or town limits, write RURAL and give nearest town)

Street No. 20 W. Kirke St

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Henry M. Lee

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	col	married

6.(b) Name of husband or wife: Geneva Lee

6.(c) If alive, give age: 44 years

7. Birth date of deceased (mo., day, yr.): Apr 30 1909

8. AGE:

Years	Months	Days	If less than one day
38	0	20	...hrs. ...min.

9. Birthplace: Va.

(Town, county, and state)

10. Usual occupation: Butler

11. Industry or business

FATHER

12. Name: unknown

13. Birthplace

MOTHER

14. Maiden name: unknown

15. Birthplace

16. Informant: Geneva Lee

Address: 20 W. Kirke St. Chevy Chase Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5/21/47 (month) (day) (year)

Cemetery or crematory: Beaver Dam

Location: Va

18. Funeral director: John T. Stewart Jr.

Address: 30 N. Ct. St. Me.

19. May 20 1947 (Date rec'd by registrar) Wm E Jolley Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 20 19 47, at 9:20 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1946 to 19...

and that I last saw h... alive on ... 19...

	DURATION
Immediate cause of death	
Pulmonary hemorrhage	15 min.
Due to: pulmonary tuberculosis	5 yrs.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Frank J. Bouchat M.D. Med. Exam. M. D. or other

Address: Hagerstown Md Date signed 5-20-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04178

46f

Reg. Diat. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: 34 Quincy St. Chevy Chase Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 30 years.

Hospital, institution, or street address where death occurred: 34 Quincy Street Chevy Chase Md.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Chevy Chase Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 34 Quincy
(If rural, give LOCATION)

2.(a) If veteran, name war: No

3.(a) FULL NAME: George Arthur Lewis.

3.(b) Social Security Number: No

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed.

6.(b) Name of husband or wife: Florence Bell Crawford

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): March 18 1865.

8. AGE: Years	Months	Days	If less than one day
82.	One.	24.	..... hrs. ..... min.

9. Birthplace: Unknown
(Town, county, and state)

10. Usual occupation: Advertising Executive

11. Industry or business: Advertising.

FATHER
12. Name: Albert Henry Lewis.
13. Birthplace: Boston Mass

MOTHER
14. Maiden name: ? Hunter
15. Birthplace: Unknown.

16. Informant: Albert C. Lewis - son.

Address: 34 Quincy St. Ch. Ch. Md.

17. Cremation (Burial, cremation, or removal. Which?) Date thereof: 5 14 1947 (month) (day) (year)

Cemetery or crematory: Cedar Hill

Location: Suitland Md.

18. Funeral director: Joe Gawler's Sons

Address: 1756 Penn Ave. N.W.

19. 5/12 19 47 Mrs E Jolson Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: 12 May 1947 at 11:50 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 17 March 1947 to 12 May 1947 and that I last saw him alive on 10 May 1947

Immediate cause of death

	DURATION
1. Myocardial degeneration	2 weeks.
2. Pneumonia.	1 week.
Due to: Carcinoma of the Liver.	1 year. ?
Due to:	
Other conditions: Calculi multiple of urinary bladder + Cystitis	

(Include pregnancy within 3 months of death)

Major findings of operations: None.

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: John D. Bell - M.D.
M. D. or other

Address: 7936 Georgetown Rd - Bethesda Date signed: 12 May 47.

VS/A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

10021

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

107

C4179

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County Montgomery

City or town Bethesda (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 weeks

Hospital, Institution, or street address where death occurred: Suburban Hospital

How long in hospital or institution? 10 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Maryland County Baltimore

City or town Baltimore (If outside city or town limits, write RURAL and give nearest town)

Street No. 1702 E. Lafayette Place (If rural, give LOCATION)

2.(a) If veteran, name war None

3.(a) FULL NAME Miss Bertha Liston

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife None

6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Jan. 8, 1877

8. AGE: Years	Months	Days	If less than one day
70 70	4	0	— hrs. — min.

9. Birthplace Indiana (Town, county, and state)

10. Usual occupation Office manager

11. Industry or business —

FATHER 12. Name Edmund Liston

FATHER 13. Birthplace Unknown

MOTHER 14. Maiden name Almira Jane Callahan

MOTHER 15. Birthplace Illinois

16. Informant Mrs. J. W. Moller (cousin)

Address 4613 Ch. Ch. Blvd., Balto., Md.

17. Cremation (Burial, cremation, or removal. Which?) Date thereof May 10, 1947 (month) (day) (year)

Cemetery or crematory Cedar Hill Cemetery

Location Maryland

18. Funeral director W. Reuben Pumphrey

Address Bethesda, Md.

19. 5/10 1947 (Date rec'd by registrar) Wm E Jabes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 8 1947, at 11:35 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Apr 26 1947, to May 9, 1947 and that I last saw h.. alive on May 8, 1947

Immediate cause of death	DURATION
Pulmonary embolism	1 day
Due to Bronchopneumonia	8 days
Due to	
Other conditions Neoplastic Thyroid Malignancy questionable	5

(Include pregnancy within 3 months of death) [Apr 25 '47 abc]

Major findings of operations

Date of op.

Autopsy results as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE C. G. Bauereisen M.D. M. D. or other

Address Bethesda, Md Date signed 5/10/47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

932

04180

CERTIFICATE OF DEATH

Reg. Diat. No. 216

1. PLACE OF DEATH:

County Montgomery

City or town Bethesda (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? All life in County 2 Days in Bethesda

Hospital, Institution, or street address where death occurred: Suburban Hospital

How long in hospital or institution? 2 days 22 hours

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Gaithersburg - Rural (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war No

3.(a) FULL NAME Richard T. Lowe

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	married

6.(b) Name of husband or wife Bertha Lowe

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 25 1885

8. AGE: Years 61 | Months 10 | Days 4 | If less than one day ..... hrs. ..... min.

9. Birthplace Montgomery County (Town, county, and state)

10. Usual occupation Milk Truck Driver

11. Industry or business

FATHER 12. Name Lawerance Lowe

13. Birthplace Montgomery County Md

MOTHER 14. Maiden name Cora Rebecca Selby

15. Birthplace Montgomery Co. Md

16. Informant Wife (Mrs Bertha Lowe)

Address Rt 3 Gaithersburg Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6/1/47 (month) (day) (year)

Cemetery or crematory Darnestown Church Cem.

Location Darnestown, Maryland

18. Funeral director Wm Reuben Dempfrey

Address Bethesda, Maryland

19. 5/30 1947 (Date rec'd by registrar) Wm E Jones Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 29 1947 at 8:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h.....ative on ..... 19.....

Immediate cause of death	DURATION
(a) CORONARY OCCLUSION	
Due to (b) ARTERIOSCLEROTIC HEART DISEASE	
Due to (c)	
Other conditions HYPERTENSIVE CARDIO VASCULAR DISEASE, CHOLECYSTITIS	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE C. E. Bowles M.D. M. D. or other

Address Rockville Md Date signed 5/29/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d

04181

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 19 days

Hospital, institution, or street address where death occurred:

US Naval Hospital, Bethesda, Md.

How long in hospital or institution? 19 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: D.C. County:

City or town: Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No. 148 Bryant St., N.W.

(If rural, give LOCATION)

2.(a) If veteran, name war: Sp.Am.

3.(a) FULL NAME: LUSKEY, John Jacob

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	married

6.(b) Name of husband or wife: Mrs. Mary E. Luskey

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): 3 October 1870

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
76	7	2		

9. Birthplace: D.C. (Town, county, and state)

10. Usual occupation: Veteran

11. Industry or business: unemployed

FATHER — 12. Name: John Luskey dec.

FATHER — 13. Birthplace: unknown

MOTHER — 14. Maiden name: Elizabeth Williams

MOTHER — 15. Birthplace: Md.

16. Informant: wife: Mrs. Mary E. Luskey

Address: 148 Bryant St., N.W., Wash., D.C.

17. burial (Burial, cremation, or removal. Which?) Date thereof: 5-8-47 (month) (day) (year)

Cemetery or crematory: Arlington National Cemetery

Location: Arlington, Va.

18. Funeral director: W. W. CHAMBERS — [illegible]

Address: 1400 Chapin St., N.W.

19. 5-5 1947 (Date rec'd by registrar) Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 5 May 1947 at 1:27P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 16 1947 to 5 May 1947 and that I last saw h. im alive on 5 May 1947

Immediate cause of death	DURATION
Bronchial Pneumonia	1 week
Due to Congestive Heart Failure	1 Month
Due to Arteriosclerotic Heart Disease	16 years
Other conditions: Cerebrovascular Accident	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work? .....

23. SIGNATURE: D. W. Mulder D. W. MULDER, Lt.(jg)(MC) USNR M. D. or other

Address: USNH Bethesda, Md. Date signed: 5-5-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

5/6/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83a

04182

CERTIFICATE OF DEATH

Reg. Diat. No. 218

1. PLACE OF DEATH:
County Montgomery
City or town Silver Spring, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn Infants give residence of mother)
State Md. County Montgomery
City or town Silver Spring
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war None

3. (a) FULL NAME Minna S. Mantz

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 29, 1864

8. AGE: Years	Months	Days	If less than one day
83	1	22	hrs. min.

9. Birthplace Virginia
(Town, county, and state)

10. Usual occupation None

11. Industry or business

FATHER
12. Name Peter Mantz
13. Birthplace Virginia

MOTHER
14. Maiden name Mary M. Buscard
15. Birthplace Virginia

16. Informant G. Earl Mantz
Address Silver Spring, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 23, 1947 (month) (day) (year)
Cemetery or crematory Rose Hill
Location Hagerstown, Md.

18. Funeral director Dayhoff Barber
Address Boonsboro Md.

19. May 22 1947 Almeda L. Cooke
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May - 20 - 47 19 at 10 30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May - 19 - 1947 to May - 20 - 1947 and that I last saw h.. alive on May - 20 - 1947

Immediate cause of death	DURATION
Cerebral Hemorrhage	2 days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE William C. Miller, M.D.
M. D. or other
Address Gaithersburg, Md. Date signed 5/21/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

04183

CERTIFICATE OF DEATH

Reg. Diat. No. 218

1. PLACE OF DEATH:

County: Montg Co -

City or town: Boyds - (Rural)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 85 yrs -

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Boyds

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Josephine McAtee

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife: —

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Jan 4/1862

8. AGE: Years	Months	Days	If less than one day
1862 85	4	14	..... hrs. ..... min.

9. Birthplace: Boyds, Md.

(Town, county, and state)

10. Usual occupation: Seamstress (Retired)

11. Industry or business: "

FATHER — 12. Name: John S. McAtee

FATHER — 13. Birthplace: Md -

MOTHER — 14. Maiden name: Anne Muntead

MOTHER — 15. Birthplace: Md -

16. Informant: E. A. McAtee

Address: Boyds Md -

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5/21/47 (month) (day) (year)

Cemetery or crematory: St Rose Cemetery

Location: Clopper Md -

18. Funeral director: Emerick & Gaither

Address: Gaithersburg Md

19. May 20 1947 (Date rec'd by registrar) Alvin L. Poole Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 18 1947 at 7 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 26, 1945, to May 18, 1947

and that I last saw h. E.D. alive on May 15, 1947

Immediate cause of death: Arteriosclerotic cardio-vascular disease

DURATION: 20 years.

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: James P. Kerr M.D.

M. D. or other

Address: Dickerson, Md. Date signed 5/19/47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correctness is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 124b

CERTIFICATE OF DEATH

04184

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 months, 4 days

Hospital, institution, or street address where death occurred:

US Naval Hospital, Bethesda, Md.

How long in hospital or institution? 2 months, 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Pa. County:

City or town: Stonehurst

(If outside city or town limits, write RURAL and give nearest town)

Street No. 3 Marlbourgh Road

(If rural, give LOCATION)

2.(a) If veteran, name war: WW 1

3.(a) FULL NAME: McNALLY, John Edward

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	widowed

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): August 13, 1898

8. AGE: Years	Months	Days	If less than one day
48	8	18	hrs. min.

9. Birthplace: Mass.

(Town, county, and state)

10. Usual occupation: Veteran

11. Industry or business:

FATHER — 12. Name: John McNally dec.

13. Birthplace: Mass.

MOTHER — 14. Maiden name: Ann LaFurrey dec.

15. Birthplace: Mass.

16. Informant: daughter: Miss Katherine A. McNally

Address: 3 Marlbourgh Road, Stonehurst, Penn.

17. burial (Burial, cremation, or removal. Which?) Date thereof: 5-5-47 (month) (day) (year)

Cemetery or crematory: Arlington National

Location: Arlington, Va.

18. Funeral director: W. W. CHAMBERS W.J.T.

Address: Georgetown, D.C.

19. 5-2- (Date rec'd by registrar) 1947 Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 1 May 19 47 at 9:30A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 27 19 47, to 1 May 19 47 and that I last saw him alive on 1 May 19 47

Immediate cause of death	DURATION
Hemorrhage	40 hrs.
Due to: Esophageal Varix	4 yrs.
Due to: Hepatic Cirrhosis	10 yrs.
Other conditions: ascites	10 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations: Umbilical Hernia

Date of op. 4-20-47

Autopsy results: Varicites, ascites, Cirrhosis

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: W. B. Ford W. B. FORD, Lt.(MC) USN

M. D. or other

Address: USNH Bethesda, Md. Date signed 5-2-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15 9-45-15M

5/12/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

CERTIFICATE OF DEATH

04185

Reg. Dist. No. 2231

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Montgomery

City or town: Takoma Park, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 16 days.

Hospital, Institution, or street address where death occurred:
Washington Sanitarium and Hospital

How long in hospital or institution? 16 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: ..... County: .....

City or town: Washington, D.C.
(If outside city or town limits, write RURAL and give nearest town)

Street No. 5712 Columbia Avenue, N.W.
(If rural, give LOCATION)

2.(a) If veteran, name war: .....

3.(a) FULL NAME: Merchant, William Arthur

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Cauc.	Widowed

6.(b) Name of husband or wife: Merchant Martha Susan

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): April 16, 1861

8. AGE: Years	Months	Days	If less than one day
86	1	6	..... hrs. ..... min.

9. Birthplace: Poolesville, Maryland
(Town, county, and state)

10. Usual occupation: Retired

11. Industry or business: .....

FATHER
12. Name: James F. Merchant
13. Birthplace: Maryland

MOTHER
14. Maiden name: Sarah Morrison
15. Birthplace: Maryland

16. Informant: Washington Sanitarium and Hospital Records
Address: Takoma Park, Maryland

17. Burial
(Burial, cremation, or removal. Which?) Date thereof 5-22-47 (month) (day) (year)

Cemetery or crematory: Berryville Va.

Location: Washington D.C.

18. Funeral director: Deal Funeral Home.

Address: 4812 - Ga. Ave. N.W. Washington, D.C.

19. 5-22 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 5-22 1947, at 4:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5-6 1947 to 5-22 1947 and that I last saw him alive on 5-22 1947

Immediate cause of death	DURATION
Terminal Pneumonia	3 days
Due to: Arteriosclerosis	8 years
Due to: Heart Disease	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) ..... (County) ..... (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Dr. Vork Made M.D.

Address: Takoma Park, Md. M. D. or other

Date signed: 5-22-47

M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 117a

CERTIFICATE OF DEATH

C4187

Reg. Dist. No. 223

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
County Montgomery
City or town Takoma Park
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 days
Hospital, institution, or street address where death occurred:
Washington Sanitarium and Hospital
How long in hospital or institution? 6 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State District of Columbia County
City or town Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2962 2nd Street, S.E., Apt. 12
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Mickel, Mr. Peter

3. (b) Social Security Number

4. Sex: Male
5. Color or race: White
6. (a) Single, married, widowed, or divorced: Married
6. (b) Name of husband or wife: Dorothy E. Mickel
6. (c) If alive, give age 33 years
7. Birth date of deceased (mo., day, yr.): January 18, 1905

8. AGE:

Years	Months	Days	If less than one day
42	4	1	hrs. min.

9. Birthplace Buffalo, New York
(Town, county, and state)
10. Usual occupation Construction Foreman
11. Industry or business Not employed recently

FATHER
12. Name Mike Mickel
13. Birthplace Poland

MOTHER
14. Maiden name Sophie ?
15. Birthplace Warsaw, Poland

16. Informant Washington San. & Hospital Records
Address Takoma Park, Maryland

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof 5/22/47
(month) (day) (year)
Cemetery or crematory Rock Creek Cem.
Location

18. Funeral director Thos. H. Hines Co.
Address 2901-14th St. N.W.

19. May 20 1947 J. Helm Dodd Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH May 19 1947, at 7:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 14, 1947, to May 19 1947 and that I last saw him alive on May 19 1947

Immediate cause of death	DURATION
Perforated Peptic ulcer	5 days
Generalized Peritonitis	5 "
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Perforated Peptic ulcer, c̄ peritonitis Date of op. May 15/47
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur?
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Herman J. Slotkin(?) M.D. or other
1008 N. Highland St.
Address Arlington, Va. Date signed 5-19-47

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04186

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 27 hours
Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.
How long in hospital or institution? 27 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D. C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1431 Jackson St., N.E.
(If rural, give LOCATION)
2.(a) If veteran, name war: WWI

3.(a) FULL NAME: MILTON, DeWane Lightfoot

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	Col-US	married

6.(b) Name of husband or wife: Mrs. Carrie Milton
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 12 August 1895

8. AGE: Years	Months	Days	If less than one day
51	9	6	hrs. min.

9. Birthplace: Washington, D.C.
(Town, county, and state)
10. Usual occupation: Cab Driver
11. Industry or business:

FATHER
12. Name: MILTON, Monouth dec.
13. Birthplace: N.Y.

MOTHER
14. Maiden name: LIGHTFOOT, Florence dec.
15. Birthplace: Va.

16. Informant: wife: Mrs. Carrie Milton
Address: 1431 Jackson St., N.E., Wash., D.C.

17. burial (Burial, cremation, or removal. Which?) Date thereof 5-22-47 (month) (day) (year)
Cemetery or crematory: Arlington National
Location: Arlington, Va.

18. Funeral director: W. Ernest Jarvis
Address: 1432 U St., N.W., Wash., D.C.

19. May 19 1947 (Date rec'd by registrar) Mary Charlotte Smith (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: 18 May 1947 at 2:55 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 17 May 1947 to 18 May 1947 and that I last saw him alive on 18 MAY 1947

Immediate cause of death	DURATION
CORONARY THROMBOSIS, ARTERIOSCLEROSIS	4 MONTHS (LATEST — 2-4 HOURS)
Due to: ARTERIOSCLEROSIS	
Due to:	
Other conditions: CONGESTIVE HEART FAILURE, COMPENSATED; CEREBRAL INFARCTION	4 MONTHS

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.
Autopsy results: AS ABOVE
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: J. B. Bryan
J. B. BRYAN, Lt.(jg)(MC) USN
M. D. or other
Address: USNH Bethesda, Md. Date signed: 5-19-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

5/26/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

CERTIFICATE OF DEATH

04188

Reg. Diat. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 month, 23 days

Hospital, Institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.

How long in hospital or institution? 1 month, 23 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Va. County:

City or town: Vienna
(If outside city or town limits, write RURAL and give nearest town)

Street No. RFD #2, Box 111
(If rural, give LOCATION)

2.(a) If veteran, name war: Sp. Am. War

3.(a) FULL NAME: MOELLER, Julius

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	married

6.(b) Name of husband or wife: Ethel L. Moeller

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 12 July 1884

8. AGE: Years	Months	Days	If less than one day
62	9	26	hrs. min.

9. Birthplace: Czechoslovakia
(Town, county, and state)

10. Usual occupation: Guard

11. Industry or business: National Air Port,

FATHER
12. Name: Moeller, Julius dec

13. Birthplace: Czechoslovakia

MOTHER
14. Maiden name: Riesner, Frances dec.

15. Birthplace: Czechoslovakia

16. Informant: wife: Mrs. Ethel L. Moeller

Address: RFD #2, Box 111, Vienna, Va.

17. burial (Burial, cremation, or removal. Which?) Date thereof: 5-12-47 (month) (day) (year)

Cemetery or crematory: Arlington National

Location: Arlington, Va.

18. Funeral director: W. W. CHAMBERS W.J.T.

Address: Georgetown, D.C.

19. 5-8 19 47 (Date rec'd by registrar) Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

A

20. DATE OF DEATH: 8 May 19 47 at 9:11 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 15 March 19 47, to 8 May 19 47 and that I last saw h im alive on 8 May 19 47

Immediate cause of death	DURATION
CORONARY HEART DISEASE	
Due to ARTERIOSCLEROSIS	
Due to	
Other conditions PULMONARY INFARCTS	

(Include pregnancy within 3 months of death)

Major findings of operation:

Autopsy results: CORONARY THROMBOSIS WITH MYOCARDIAL INFARCTION, Date of GENERALIZED ARTERIOSCLEROSIS, PULMONARY INFARCTION

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: J. C. Bryan J. C. BRYAN, Lt.(jg)MC) USNR M. D. or other

Address: USNHBethesda, Md. Date signed: 5-8-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

5/17/47

C4190

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

CERTIFICATE OF DEATH

Reg. Dist. No. 714

1. PLACE OF DEATH:
County: Montgomery
City or town: Silver Spring
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 9 years
Hospital, institution, or street address where death occurred:
9414 Georgia Avenue
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Silver Spring, Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 9414 Georgia ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Ida B. Mullen

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	Widowed

6.(b) Name of husband ~~or wife~~ Wallace A. Mullen

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Oct. 25, 1872

8. AGE:

Years	Months	Days	If less than one day
74	6	10	..... hrs. ..... min.

9. Birthplace Frederick County Maryland
(Town, county, and state)

10. Usual occupation At Home

11. Industry or business

FATHER
12. Name William Hopper
13. Birthplace New Orleans La

MOTHER
14. Maiden name Matilda Bekenbury
15. Birthplace Germany

16. Informant Mrs. Harriett Taylor
Address 9219 Woodland Rd Silver Spring, Md

17. Burial 5/7/47
(Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)
Cemetery or crematory Mt. Olivet Cemetery
Location Frederick, Maryland
18. Funeral director W. R. Eichelberger & Son
Address Frederick, Maryland

19. May 6 1947 Josephine M. Schaffer
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 5 1947, at 4:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1938, to May 5 1947
and that I last saw her alive on May 5 1947

Immediate cause of death	DURATION
Acute Cardiac De-Compensation	1 day
Due to	
Due to	
Other conditions Hypertension Heart Disease	—

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE J. Marion Bamford M.D.
M. D. or other
Address 9601 Sutton Pl. Silver Spring, Md. Date signed 5/5/47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 95c

04191

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH:

County Montgomery

City or town Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 days

Hospital, Institution, or street address where death occurred: Washington Sanitarium & Hospital

How long in hospital or institution? 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County

City or town Silver Spring

(If outside city or town limits, write RURAL and give nearest town)

Street No. 109 Normandy Drive

(If rural, give LOCATION)

2.(a) If veteran, name war No

3.(a) FULL NAME William B. Mullen

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Cauc.	Married

6.(b) Name of husband or wife Mrs. Alice Mullen. 6.(c) If alive, give age 51 years

7. Birth date of deceased (mo., day, yr.) August 7 1902

8. AGE: Years 44 | Months 9 | Days 15 | If less than one day ..... hrs. ..... min.

9. Birthplace Washington, D.C. (Town, county, and state)

10. Usual occupation Insurance Agent and Taxi Business

11. Industry or business Diamond Cab owner.

FATHER 12. Name Henry Mullen

FATHER 13. Birthplace Virginia

MOTHER 14. Maiden name Grace Rudderforth

MOTHER 15. Birthplace Washington D.C.

16. Informant Records - Washington San. & Hospital

Address Takoma Park, Md.

17. BURIAL (Burial, cremation, or removal. Which?) Date thereof MAY-20-1947 (month) (day) (year)

Cemetery ~~or crematory~~ FORT LINCOLN

Location PRINCE GEORGES Co. MD.

18. Funeral director Dame & Pumphrey

Address SILVER SPRING, MD.

19. May 19 1947 (Date rec'd by registrar) J. Wm. Dall Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 18 1947 at 5:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1942 to May 18 1947

and that I last saw him alive on May 17 1947

Immediate cause of death chron. pyelonephritis chron. pyonephrosis — DURATION: Years

Due to osteomyelitis of hip — Final years

Due to

Other conditions Uremia hypertrophy of heart & hypertension

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE J. N. Andrews M.D. M. D. or other

Address Silver Spring Md. Date signed 5-17-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83d

04192

CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH:
County: Mont Co —
City or town: Olney —
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 hours —
Hospital, Institution, or street address where death occurred: Monty. Co. Gen Hospital Inc.
How long in hospital or institution? 3 hours —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Mont —
City or town: Sunshine —
(If outside city or town limits, write RURAL and give nearest town)
Street No. Brookeville R F D
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Miss Sallie anne Myers —

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife: —

6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): 7 June 1878

8. AGE:

Years	Months	Days	If less than one day
68	10	14	hrs. min.

9. Birthplace: Montgom Co Md
(Town, county, and state)

10. Usual occupation: Home Domestic

11. Industry or business: Home

FATHER
12. Name: George W Myers.
13. Birthplace: Frederick Co md

MOTHER
14. Maiden name: Mary E Curtis
15. Birthplace: Frederick Co md

18. Informant: Mrs Margaret B. Thomas
Address: Sunshine Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 24, 1947 (month) (day) (year)
Cemetery or crematory: St Johns
Location: Olney md

18. Funeral director: Roy W. Barber
Address: Laytonsville md

19. May 22 1947 (Date rec'd by registrar) Gertrude B. Lawler Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 21 — 1947, at 4:35 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1 — 1937, to May 21 1947 and that I last saw h.er alive on May 21 — 1947

	DURATION
Immediate cause of death: Hemiplegia	16 hours
Due to: Hypertension	10 yrs
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: No
Date of op.:
Autopsy results: No
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Chas B Tumbleson M. D. or other
Address: Sandy Spring Date signed: 5/22/1947

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 5-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

04193

CERTIFICATE OF DEATH

Reg. Dist. No. 716

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A1B 9-45-15M

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 week

Hospital, institution, or street address where death occurred: Suburban Hospital

How long in hospital or institution? 6 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants, give residence of mother)

State: Maryland County: Montgomery

City or town: Chevy Chase (If outside city or town limits, write RURAL and give nearest town)

Street No. 214 Spring St. (If rural, give LOCATION)

2.(a) If veteran, name war: no

3. (a) FULL NAME: Mrs - Mary E. Odom

3. (b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	married

6.(b) Name of husband or wife: John B. Odom

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Oct - 21, 1876

8. AGE:

Years	Months	Days	If less than one day
70	7	4	..... hrs. ..... min.

9. Birthplace: Princess Anne County, Va. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Home

FATHER

12. Name: Joseph Ewell

13. Birthplace: Princess Anne Co. Va

MOTHER

14. Maiden name: Mary Fontress

15. Birthplace: Princess Anne Co Va

16. Informant: daughter Mrs - Margaret Cutler

Address: 214 Spring St - Ch. Ch. Md.

17. Burial - Transit (Burial, cremation, or removal. Which?) Date thereof: May 18, 1947 (month) (day) (year)

Cemetery or crematory: Norbeck Cemetery

Location: Norbeck, Virginia

18. Funeral director: Wm. Reardon Humphreys

Address: Bethesda, Maryland

19. 5/18 19 47 (Date rec'd by registrar) Wm E Jobes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 17, 19 47, at 5:55 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Apr 22 19 47 to May 17, 19 47 and that I last saw h.. alive on May 17, 19 47

	DURATION
Immediate cause of death: acute cardiac insufficiency	1 wk.
Due to: Chr. hypertensive heart disease	5 yrs.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: E. G. Bauerfeind M.D. M. D. or other

Address: Bethesda, Md Date signed: 5/18/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

04194

CERTIFICATE OF DEATH

Reg. Diat. No. 213

1. PLACE OF DEATH:
County Montgomery
City or town near Rockville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infant give residence of mother)
State Maryland County Montgomery
City or town near Rockville
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Arthur Offutt

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	Colored	Widowed

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 3. 1882

8. AGE:

Years	Months	Days	If less than one day
65	1	11	hrs. min.

9. Birthplace Montgomery Co., Md.
(Town, county, and state)
10. Usual occupation Laborer
11. Industry or business

FATHER
12. Name unknown
13. Birthplace

MOTHER
14. Maiden name Sarah Offutt
15. Birthplace Montgo. Co. Md.

16. Informant Mary Smith
Address Rockville, Md.

17. Burial Date thereof May 18, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Haiti Cemetery
Location Rockville, Md.

18. Funeral director R. L. Snowden
Address Rockville, Md.

19. May 18 1947 Mrs E.P Thompson
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 15th 19 47 at 3:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1936 19 to MAY 15 19 47 and that I last saw h. alive on MAY 15 19 47

Immediate cause of death	DURATION
Congestive heart Failure	1 Day
Due to Hypertensive heart Disease	10 years
Due to Hypertension	15 years
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Della Walsh M. D. or other
Address Rockville Date signed 5/17/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15 9-45-15M

Evidence for change of birthdate shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

462 04195 V 14

FILM No. G 110 JUN 4 1947

Reg. Dist. No.

1. PLACE OF DEATH:
County Montgomery County
City or town Silver Springs
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 month
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State County
City or town Washington, D C
(If outside city or town limits, write RURAL and give nearest town)
Street No. 3110 - 35th St, N E
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Minnie E. Ogden

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	Widowed

6.(b) Name of husband or wife James F.
6.(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) January 6, ~~1949~~ 1871

8. AGE: Years 76 Months Days If less than one day hrs. min.

9. Birthplace Carthage, Missouri (Town, county, and state)
10. Usual occupation Housewife
11. Industry or business
FATHER 12. Name George B. Walker
13. Birthplace Missouri
MOTHER 14. Maiden name Eliza Stith
15. Birthplace Missouri
16. Informant Joseph W. Ogden
Address 300-34 St, S.E. Wash. D.C.
17. Burial (Burial, cremation, or removal. Which?) Date thereof May 30 1947 (month) (day) (year)
Cemetery or crematory
Location Carthage, Missouri
18. Funeral director W. W. Chambers Co.
Address 517-11th St. S.E.
19. May 26 1947 (Date rec'd by registrar) Josephine Schaeffer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 26 1947 at 11:00 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 26 1947 to May 26 1947 and that I last saw h.. alive on April ~~May~~ 25 1947

Immediate cause of death	DURATION
Carcinoma of Intestines	
Due to	
Due to	
Other conditions Senility	

(Include pregnancy within 3 months of death)

Major findings of operations None Date of op.
Autopsy results None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Henry M. Lowder M.D. (M. D. or other)
Address 1603 19th N.W. Date signed 5-26-47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

124 b

04196

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 days
Hospital, institution, or street address where death occurred:
USNH, Bethesda, Maryland
How long in hospital or institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D. C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 915 K Street, SE
(If rural, give LOCATION)
2.(a) If veteran, name war: WW I

3.(a) FULL NAME
PARKER, Robert Lee

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	widowered

6.(b) Name of husband or wife: widowered
6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): 11 April 1887

8. AGE: Years	Months	Days	If less than one day
60	0	29	..... hrs. ..... min.

9. Birthplace: Virginia (Town, county, and state)
10. Usual occupation: Government Accountant
11. Industry or business: U. S. Government

FATHER
12. Name: Robert Lee Parker
13. Birthplace: Virginia

MOTHER
14. Maiden name: Lilintine Tinsbloom
15. Birthplace: Virginia

16. Informant: Sister: Nora E. Sabin
Address: 915 K St., SE, Washington, D. C.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 5-13-47 (month) (day) (year)
Cemetery or crematory: Arlington National
Location: Arlington, Virginia

18. Funeral director: W. W. Chambers Co. F.H.
Address: 517 11th St., SE, Washington, D. C.

19. 5-10- 1947 (Date rec'd by registrar) Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 10 ~~XXXX~~ May 1947 at 3:50 A.M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 8 May 1947, to 10 May 1947 and that I last saw him alive on 10 May 1947

Immediate cause of death	DURATION
Hemorrhage from esophageal varices.	72 hours
Due to: Portal cirrhosis of the liver	indefinite
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operation: None performed
Date of op.:
Autopsy results: Not obtained.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Paul R. Engle
PAUL R. ENGLE, CDR MC USN
M. D. or other
Address: USNH, Bethesda, Md. Date signed: 5/13/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

5/17/47

Evidence for the change of date of birth is shown on G 111 8/20/47

4513

94a

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. .....

1. PLACE OF DEATH:

County Montgomery

City or town Silver Spring,

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? .....

Hospital, Institution, or street address where death occurred:

How long in hospital or institution? -----

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Silver Spring,

(If outside city or town limits, write RURAL and give nearest town)

Street No. 8300 - 16th Street

(If rural, give LOCATION)

2.(a) If veteran, name war -----

3.(a) FULL NAME DR. WALDO R. PEARCE

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife Julia M. Pearce

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) February 17, 1883

8. AGE: Years	Months	Days	If less than one day
64			..... hrs. ..... min.

9. Birthplace Brooklyn, New York (Town, county, and state)

10. Usual occupation Dentist

11. Industry or business

FATHER 12. Name Henry O. Pearce

13. Birthplace New York

MOTHER 14. Maiden name Mary Stevens

15. Birthplace New York

16. Informant Mr. Philip D. Dudley

Address 2434 - 16th Street N.W., Wash. D.C.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 27, 1947 (month) (day) (year)

Cemetery or crematory Rock Creek Cemetery

Location WASHINGTON, D.C.

18. Funeral director Martin W. Hyong Co.

Address 1300 - N Street N.W., Wash. D.C.

19. August 15, 1947 (Date rec'd by registrar) A. W. Hedrich Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 25th 24 1947 at 11.30 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 2nd, 1947, to May 24th 1947 and that I last saw him alive on May 24th 1947

Immediate cause of death	DURATION
Heart Failure	
Heart Block	
Due to Coronary Occlusion	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Carl Burkhardt M.D. M. D. or other

Address 1801-Eye St. NW, Wash. D.C. Date signed May 25/47

We didn't issue the
burial permit on this.
Washington Health Dept
issued the permit. DS

(over) film G 145 7/22/52 - cmc

NOTE: Certificate received in VITAL RECORDS OFFICE

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

JUL 22 1952

Reg. Dist. No. 215 Reg. No. 216

(Filed in registration district 1947)

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 29 hours, 15 minutes

Hospital, institution, or street address where death occurred:

US Naval Hospital, Bethesda, Md.

How long in hospital or institution? 29 Hours, 15 minutes

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: D.C. County:

City or town: Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No. 3402 15th St., S.E.

(If rural, give LOCATION)

2.(a) If veteran, name war: WW II

3.(a) FULL NAME: PETERSON, McCLIFTON (n)

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colord	Married

6.(b) Name of husband or wife: Mrs. Crecia Peterson

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): April 4, 1920

8. AGE:

Years	Months	Days	If less than one day
27	1	2	..... hrs. ..... min.

9. Birthplace: S.C. (Town, county, and state)

10. Usual occupation:

11. Industry or business: National Air Port

FATHER — 12. Name: Hercules Peterson

FATHER — 13. Birthplace: S.C.

MOTHER — 14. Maiden name: Inez Owens

MOTHER — 15. Birthplace: S.C.

16. Informant: wife: Mrs. Crecia Peterson

Address: 3402 15th St., S.E., Wash., D.C.

17. removal (Burial, cremation, or removal. Which?) Date thereof: 5-7-47 (month) (day) (year)

Cemetery or crematory:

Location:

18. Funeral director: W. Ernest Jarvis R.F.D.

Address: 1432 U St., N.W., Wash., D.C.

7/23/52 5-7 19 47 (Date rec'd by registrar) Mary Charlotte Smith Edith Whittington Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 6 May 19 47, at 9:15P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5 May 19 47, to 6 May 19 47 and that I last saw him alive on 6 May 19 47

Immediate cause of death	DURATION
Massive Cerebral Hemorrhage due to	
Subarachnoid Hemorrhage.	
Due to: Inciting Cause history of	
being struck on head.	
Due to:	
Other conditions: 330.x	

(Include pregnancy within 3 months of death)

Major findings of operations: None done Date of op.

Autopsy results: Massive intracerebral Hemorrhage into ventricular system. Subarachnoid Hemorrhage.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

E. N. Weaver

23. SIGNATURE: E. N. WEAVER, Lt. (jg) (MC) USNR M. D. or other

Address: USNH Bethesda, Md. Date signed: 5-7-47

MARGIN RESERVED FOR BINDING

PUBLIC HEALTH ITEM I

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04197

46b

CERTIFICATE OF DEATH

Reg. Dist. No. 22 3

1. PLACE OF DEATH:
County: Montgomery
City or town: Takoma Park
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: 15 Oak Ave.
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Takoma Park
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 15 Oak Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: RAYMOND A. PUMPHREY

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W.	

6.(b) Name of husband or wife: Anna C. Pumphrey
8.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Feb. 6, 1879

8. AGE:

Years	Months	Days	If less than one day
68	3	18	hrs. min.

9. Birthplace: Washington, D.C. (Town, county, and state)
10. Usual occupation: Plumber
11. Industry or business: Some
FATHER 12. Name: Richard I. Pumphrey
13. Birthplace: Baltimore, Md.
MOTHER 14. Maiden name: Unknown
15. Birthplace: Unknown
16. Informant: Mrs. Raymond Pumphrey
Address: 15 Oak Ave. Tak. Pk. Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 27, 1947 (month) (day) (year)
Cemetery or crematory: Glenwood Cemetery
Location: Washington, D. C.
18. Funeral director: Arthur Walters
Address: 254 Carroll Ave. Tak. Pk. Md.
19. 5 27 47 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 24 19 47 at 5:20 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 19 47 to May 24 19 47
and that I last saw h. alive on May 23 19 47

	DURATION
Immediate cause of death: Carcinoma of Stomach & Intestines	6 months
Due to: Pulmonary Edema	2 days.
Due to:	
Other conditions: Acute Congestive Heart Failure	1 Mth. 15 days

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Francis J. Richardson M. D. or other
Address: 777 Alaska Ave. N.W. Date signed: 5/24/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

VS A15 9-45-15M

Evidence for change of age shown on:

04198

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

JUN 13 1947 FILE No. G 11[illegible] JUN 13 1947

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 days

Hospital, institution, or street address where death occurred:

US Naval Hospital, Bethesda, Md.

How long in hospital or institution? 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: D.C. County:

City or town: Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 1609 13th St., N.W.

(If rural, give LOCATION)

2.(a) If veteran, name war: WW 1

3.(a) FULL NAME: QUEEN, George Alexander

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	Col. US	married

6.(b) Name of husband or wife: Mrs. Carrie C. Queen

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): November 19, 1882

8. AGE: Years	Months	Days	If less than one day
64 -65	5	18	..... hrs. ..... min.

9. Birthplace: Md. (Town, county, and state)

10. Usual occupation: unknown

11. Industry or business:

FATHER — 12. Name: Charles Queen

13. Birthplace: Md. dec.

MOTHER — 14. Maiden name: Martha Hopkins

15. Birthplace: Md. dec.

16. Informant: wife: Mrs. Carrie C. Queen

Address: 1609 13th St., N.W., Wash., D.C.

17. burial (Burial, cremation, or removal. Which?) Date thereof: 5-12-47 (month) (day) (year)

Cemetery or crematory: Arlington National Cemetery

Location: Arlington, Va.

18. Funeral director: W. Ernest Jarvis

Address: 1432 U St., N.W., Wash., D.C.

19. 5-7 1947 (Date rec'd by registrar) Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 7 May 1947 at 1:20P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3 May 1947 to 7 May 1947 and that I last saw him alive on 7 May 1947

Immediate cause of death	DURATION
Pneumonia, Focal Bilateral. 108	5 days
Due to:	
Due to: Cirrhosis Portal. 1	?
Other conditions: 12 hrs	

(Include pregnancy within 3 months of death)

Major findings at operation: ..... Date of op. .....

Pneumonia Portal cirrhosis & ulcerated varix

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: H. F. [illegible], Lt. (jg) (MC) USNR M. D. or other

Address: USNH Bethesda, Md. Date signed: 5-7-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

5/7/47

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04199

Reg. Dist. No. 216

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 months, 15 days
Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.
How long in hospital or institution? 3 months, 15 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Montgomery
City or town: Bethesda,
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 5621 Southwick Street
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: REDFIELD, Charles Henry, Lt.Cdr.(HC) USN

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	married

6.(b) Name of husband or wife: Mrs. Florence D. Redfield
6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): December 16, 1901

8. AGE: Years	Months	Days	If less than one day
45	4	15	..... hrs. ..... min.

9. Birthplace: La.
(Town, county, and state)
10. Usual occupation: Navy
11. Industry or business:

FATHER
12. Name: James Redfield dec.
13. Birthplace: La.

MOTHER
14. Maiden name: Delia Tucker dec.
15. Birthplace: La.

16. Informant: wife: Mrs. Florence D. Redfield
Address: 5621 Southwick St., Bethesda, Md.

17. burial (Burial, cremation, or removal. Which?) Date thereof: 5-5-47 (month) (day) (year)
Cemetery or crematory: Arlington National
Location: Arlington, Va.

18. Funeral director: W. W. CHAMBERS W.J.T.
Address: Georgetown, D. C.

19. 5-2- 47 (Date rec'd by registrar)
Mary Charlotte Smith
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 1 May 1947 at 10:10P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 17 January 1947 to 1 May 1947 and that I last saw h... im alive on 1 May 1947

	DURATION
Immediate cause of death: Carcinoma of Liver	3 mo.
Due to: Carcinoma of Sigmoid	6 mo. (Duration undetermined)
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Carcinomas of Liver Date of op. 6 March '47
Autopsy results: Ca of Sigmoid
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: J. C. Owens
J. C. OWENS, Lt.Cdr.(MC) USNR
M. D. or other
Address: USNH Bethesda, Md. Date signed: 5-2-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

5/17/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

83a

C4200

Reg. Diat. No. 213

1. PLACE OF DEATH:
County Montgomery
City or town Dickerson
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 year
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Montg.
City or town Rockville
(If outside city or town limits, write RURAL and give nearest town)
Street No. ?
(If rural, give LOCATION)
2.(a) If veteran, name war ---

3.(a) FULL NAME Edward V. Roby

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife Daisy Lee Roby
6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.) October 7 - 1869

8. AGE: Years	Months	Days	If less than one day
77	7	0	... hrs. ... min.

9. Birthplace White Plains - Maryland (Town, county, and state)
10. Usual occupation Retired
11. Industry or business

FATHER	12. Name	Thomas Roby
	13. Birthplace	Maryland
MOTHER	14. Maiden name	Unknown
	15. Birthplace	Unknown

16. Informant Lee Roby - son -
Address Manor Pk - Mobeck - Maryland
17. Burial (Burial, cremation, or removal. Which?) Date thereof May 9/47 (month) (day) (year)
Cemetery or crematory Rockville Union Cem -
Location Nr - Rockville - Mont Co Md
18. Funeral director Dan'l Perkins Timanus
Address Rockville - Maryland
19. 5-9- 19 47 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 7th 19 47 at 8 A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 15 19 47 to May 7th 19 47
and that I last saw h. alive on May 4th 19 47

	DURATION
Immediate cause of death: Acute Cerebral Hemorrhage	1 Hour
Due to: Gen'l arterial Sclerosis	10 yrs.
Due to: —	
Other conditions —	

(Include pregnancy within 3 months of death)

Major findings of operations — Date of op. —
Autopsy results —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of —
Where did injury occur? — (City or town) (County) (State)
injured at home, farm, industry, public place (where?) —
Means of injury — injured at work?

23. SIGNATURE Upton D. Young M.D. M. D. or other
Address R.D. Boyds Damascus Md Signed 5/8/47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

04201

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

157m

Reg. Dist. No. 216

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 months
Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.
How long in hospital or institution? 2 months

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D.C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1141 1st St., N. W.
(If rural, give LOCATION)
2.(a) If veteran, name war: 2nd WW

3.(a) FULL NAME: ROBINSON, Joseph Edward,

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	Col-US	married

6.(b) Name of husband or wife: Bernice Robinson
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): June 8, 1920

8. AGE: Years	Months	Days	If less than one day
26	10	29	hrs. min.

9. Birthplace: Va.
(Town, county, and state)
10. Usual occupation: unemployed
11. Industry or business

FATHER
12. Name: Robinson, ?
13. Birthplace: unknown

MOTHER
14. Maiden name: Green, Cora
15. Birthplace: Va.

16. Informant: Wife: Mrs. Bernice Robinson
Address: 1141 1st St., N.W., Wash., D.C.

17. burial (Burial, cremation, or removal. Which?) Date thereof 5-12-47 (month) (day) (year)
Cemetery or crematory: Arlington National
Location: Arlington, Va.
18. Funeral director: W. Ernest JARVIS W. Ernest Jarvis Co.
Address: 1432 U St., N.W., Wash., D.C.

19. May 7 1947 (Date rec'd by registrar) Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 7 May 1947 at 10: A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7 March 1947 to 7 May 1947 and that I last saw him alive on 7 May 1947

	DURATION
Immediate cause of death: Progressive inanition following operation.	
Due to: Brain tumor (Craniopharyngioma) Congenital + benign [7/2/47 KLC]	Indefinite-many years
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op. 4-9-47
Autopsy results: Not performed
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: P. B. Bender, Lt. (jg) (MC) USNR
P. B. BENDER, Lt. (jg) (MC) USNR
M. D. or other
Address: USNH Bethesda, Md. Date signed: 5-7-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

5/24/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04202

93d

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH:

County: Montgomery

City or town: Takoma Park Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 16 days

Hospital, institution, or street address where death occurred:
Washington Sanitarium and Hospital

How long in hospital or institution? 16 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D.C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 2811 Woodley Rd. N.W.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: William Ross

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married.

6.(b) Name of husband or wife: Catherine A. Ross

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Dec. 27 1875

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
71	4	19		

9. Birthplace: River John, Nova Scotia
(Town, county, and state)

10. Usual occupation: Research Chemist

11. Industry or business:

FATHER
12. Name: Daniel Ross
13. Birthplace: Canada

MOTHER
14. Maiden name: Mary Murray
15. Birthplace: Canada

16. Informant: Sanitarium Records

Address:

17. Removal (Burial, cremation, or removal. Which?) Date thereof: 5 (month) 16 (day) 47 (year)

Cemetery or crematory:

Location:

18. Funeral director: Hall Hyatt Co.

Address: 2901-14th St. N.W.

19. May 16th 1947 (Date rec'd by registrar) J. W. Dudley Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 5-16 19 47 at 1:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5-1-47 19 to 5-16 19 47 and that I last saw h alive on 5-16 19 47

	DURATION
Immediate cause of death: Rupture of Heart due to Coronary Thrombosis of Left Anterior descending	4 days
Due to: Shock,	months
Due to: Hypertension,	
Due to: Arteriosclerosis	
Other conditions: Diverticuli of sigmoid Cholecystitis with Jaundice	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results: An abscess

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Dr Vor K. Tunis M.D.
M. D. or other

Address: Takoma Park, Md. Date signed: 5-16-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

CERTIFICATE OF DEATH

04203

Reg. Dist. No. 223

1. PLACE OF DEATH:
County Montgomery
City or town Takoma Park
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 25 years
Hospital, institution, or street address where death occurred:
1022 Flower Ave
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Montgomery
City or town Takoma Park
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1022 Flower Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Mimmie Hamid W. Sandgren

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W.	Widowed

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) March 12, 1865.

8. AGE: Years 82 | Months 2 | Days 1 | If less than one day ..... hrs. ..... min.

9. Birthplace Stockholm Sweden
(Town, county, and state)

10. Usual occupation At Home.

11. Industry or business

FATHER
12. Name August Widegren
13. Birthplace Sweden

MOTHER
14. Maiden name ?
15. Birthplace Sweden

16. Informant Mrs. Gertrude St. Mathews.
Address 1022 Flower Ave., Takoma Park Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 16, 1947 (month) (day) (year)
Cemetery or crematory Cedar Hill Cemetery
Location Penna Ave Extended - Prince Georges Co., Md.

18. Funeral director Fletcher Sellers.
Address 257 Carroll St. N.W. Takoma Park D.C.

19. May 15 1947 (Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 13 1947, at 9:05 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 1946 to May 13 1947
and that I last saw h alive on May 13 1947

	DURATION
Immediate cause of death	
Coronary occlusion	died
Due to	
Due to	
Other conditions Gangrene left leg	
Blood transfusion	4-16-47

(Include pregnancy within 3 months of death)

Major findings of operation ..... Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Frank J. Brostrom M.D. M. D. or other
Address Garrett Park Md. Date signed 5-13-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

562

04204

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 month, 17 days

Hospital, Institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.

How long in hospital or institution? 1 month, 17 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D.C. County:

City or town: Washington, D. C.
(If outside city or town limits, write RURAL and give nearest town)

Street No. 836 Varnum St., N.W.,
(If rural, give LOCATION)

2.(a) If veteran, name war: WWI

3.(a) FULL NAME: SAUNDERS, James Russell

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 13 December 1889

8. AGE: Years	Months	Days	If less than one day
57	4	25	hrs. min.

9. Birthplace: Wash., D.C.
(Town, county, and state)

10. Usual occupation: unemployed

11. Industry or business:

FATHER
12. Name: James Saunders, dec.
13. Birthplace: Va.

MOTHER
14. Maiden name: Alice Russell dec.
15. Birthplace: Md.

16. Informant: sister: Mrs. Frank A. Law, Jr.
Address: 836 Varnum St., N.W., Wash., D.C.

17. burial (Burial, cremation, or removal. Which?) Date thereof 5-12-47 (month) (day) (year)

Cemetery or crematory: Arlington National

Location: Arlington, Va.

18. Funeral director: S. H. HINES. JCK

Address: 2901 14th St., N.W., Wash., D.C.

19. 5-8 19 47 (Date rec'd by registrar) Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 8 May 19 47 at 7:35A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 21 March 19 47, to 8 May 19 47 and that I last saw h im alive on 8 May 19 47

Immediate cause of death	DURATION
Respiratory Failure	1 hr
Due to: Intracranial hypertension	undefinite
Due to: Acoustic Neuroma, bilateral	undefinite
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Internal hydrocephalus Date of op. May 7, 1947

Autopsy results: Benign third ventricle tumor (Colloid Cyst)

PHYSICIAN: Please underline the cause to which death should be charged statistically

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: E. N. Weaver
E. N. WEAVER, Lt.(jg)(MC) USNR
M. D. or other

Address: USNH Bethesda, Md. Date signed 5-8-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

5/26/47

Evidence for the chan e of marital status is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d.

04205

FILM No. G 110 JUN 10 1947

CERTIFICATE OF DEATH

Reg. Dist. No. 716

1. PLACE OF DEATH:

County Town

City or town Bethesda Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Suburban Hosp.

How long in hospital or institution? 23 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State DC County

City or town Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No. 4456 Clifton St N.W.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Marnette Sayre

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Single ~~married~~

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 24, 1879

8. AGE: Years 67 | Months 4 | Days 3 | If less than one day hrs. min.

9. Birthplace Bangor Pennsylvania (Town, county, and state)

10. Usual occupation Federal Clerk

11. Industry or business

FATHER 12. Name Lawrence Sayre

13. Birthplace Pennsylvania

MOTHER 14. Maiden name Ellen Weaver

15. Birthplace Pennsylvania

16. Informant Record

Address

17. Removals (Burial, cremation, or removal. Which?) Date thereof 5/12/47 (month) (day) (year)

Cemetery or crematory

Location Phillipsburg N.J.

18. Funeral director S. R. Wood Co.

Address 2901-14th St. N.W. Wash., D.C.

19. 5/14 1947 (Date rec'd by registrar) Wm E Jones Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 11 1947, at 5:40 PM (DST)

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4/18 1947 to 5/11 1947

and that I last saw her alive on 5/11/47 1947

Immediate cause of death	DURATION
cerebral embolism	
Due to Chronic myocardial degeneration	
Due to hypertension, carbovascular disease	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Irving L. Markus, M.D. M. D. or other

Address 4601 Leland St. Date signed 5/14/47

M

I MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct name is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04206

122 62 CD

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 days
Hospital, Institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.
How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D.C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2617 29th St., S.E.
(If rural, give LOCATION)
2.(a) If veteran, name war: 2nd WW

3. (a) FULL NAME: SCHICK, Michael Jacob

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	married

6.(b) Name of husband or wife: Blanche VanLiere Schick
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): February 19, 1909

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
38	3	7		

9. Birthplace: Ohio (Town, county, and state)
10. Usual occupation: Marine Corps
11. Industry or business:

FATHER
12. Name: SCHICK, Gotfraid dec.
13. Birthplace: Hungary

MOTHER
14. Maiden name: Malvian ?
15. Birthplace: Germany

16. Informant: wife: Mrs. Blanche V. Schick
Address: 2617 29th St., S.E., Wash., D.C.

17. burial (Burial, cremation, or removal. Which?) Date thereof: 5-29-47 (month) (day) (year)
Cemetery or crematory: Arlington National
Location: Arlington, Va.

18. Funeral director: W. W. CHAMBERS, 14 E L C.
Address: 1400 Chapin St., N.W., Wash., D.C.

19. 5-26 19 47 Mary Charlotte Smith
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 26 May 19 47, at 1:03P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 23 May 19 47, to 26 May 19 47
and that I last saw h... alive on 26 May 19 47

Immediate cause of death	DURATION
Thrombosis of Portal, Lienal and Superior mesenteric veins	4 days
Due to	
Due to	
Other conditions (1) Hemorrhagic infarction of the 3rd part of duodenum, jejunum and ileum (2) Bronchopneumonia, right upper lobe (3) Healed tuberculosis - inactive	4 days

(Include pregnancy within 3 months of death)
Major findings of operation: none Date of op.
Autopsy results: as above.
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: W. J. C. OWENS, Lieut Cdr. MC USNR
M. D. or other
Address: USNH Bethesda, Md. Date signed: 5-26-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

6 VS A15 9-45-15M

6/15/48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

1700 04207

Reg. Diat. No. 216

1. PLACE OF DEATH:

County Montgomery

City or town Bethesda, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? ½ hour

Hospital, Institution, or street address where death occurred:

Suburban Hospital-8600 Old Georgetown Rd.,

How long in hospital or institution? ½ hr. Bethesda, Md.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Poolesville

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME James Randolph Schultz JAMES LINCOLN SCHULTZ, SR.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) ~~Single~~, married, ~~widowed, or divorced~~
M	W	

6.(b) Name of ~~husband~~ or wife Goldie Baugher

6.(c) If alive, give age 42 years

7. Birth data of deceased (mo., day, yr.) June 27, 1902(?)

8. AGE: Years	Months	Days	If less than one day
~~100~~ 44	10	15	..... hrs. ..... min.

9. Birthplace Reading Pennsylvania (Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

FATHER 12. Name John Schultz

13. Birthplace Lebanon Pennsylvania

MOTHER 14. Maiden name Betsy Eckhart

15. Birthplace Berks Co., Pennsylvania

16. Informant Mrs. James Creager

Address 66 Taney Apt's., Frederick, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 15, 1947 (month) (day) (year)

Cemetery or crematory Mt. Olivet Cemetery

Location Frederick, Md.

18. Funeral director M. R. Etchison & Son,

Address Frederick, Md.

19. 14 May 1947 (Date rec'd by registrar) Jm E Johns Registrar

MEDICAL CERTIFICATION

35

20. DATE OF DEATH 5-12-47 19.... at 10 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec'd med. Exam 19.... to Dec'd 19....

and that I last saw h.... alive on 19....

Immediate cause of death	DURATION
Intra-cranial hemorrhage	1 hr.
Due to fracture of skull, (accidental)	
Due to	
Other conditions	

MV Comm says Mtr Vehicle accident

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accidental Date of 5-12-47

Where did injury occur? Poolesville (City or town) county (County) Md (State)

Injured at home, farm, industry, public place (where?) highway

Means of injury Fell from Truck Injured at work? yes

23. SIGNATURE Frank J. Bosckart M.D. Dec'd Med. Exam. M. D. or other

Address Gaithersburg Date signed 5-13-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

04208

CERTIFICATE OF DEATH

Reg. Dist. No. 714

1. PLACE OF DEATH:

County: Montgomery

City or town: Silver Spring
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
8402 Georgia Ave.,

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Silver Spring
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 8402 Ga. Ave.,
(If rural, give LOCATION)

2.(a) If veteran, name war: no

3. (a) FULL NAME: ANDREAS SCOTARAKOS

3. (b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	widowed

6.(b) Name of husband or wife: Unknown

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Nov. 30th. 1862

8. AGE: Years	Months	Days	If less than one day
84	5	1	....hrs. ....min.

9. Birthplace: Greece
(Town, county, and state)

10. Usual occupation: Florists helper

11. Industry or business:

FATHER
12. Name: Unknown
13. Birthplace: Greece

MOTHER
14. Maiden name: Unknown
15. Birthplace: Greece

16. Informant: Mr. Tom Jianos

Address: 8402 Ga. Ave. Silver Spring.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 3rd 1947 (month) (day) (year)

Cemetery or crematory: Rock Creek

Location: Washington, D. C.

18. Funeral director: Warner E Pumphrey

Address: Silver Spring, Maryland.

19. May 2 (Date rec'd by registrar) 1947 Josephine M Schaeffer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 1 19 47, at 12:10 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..., to ..... 19...

and that I last saw ... alive on ..... 19...

	DURATION
Immediate cause of death:	
Coronary occlusion	sudden
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operation: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Frank J. Brochard M.D. Dy Med. Exam. M. D. or other

Address: Gaithersburg Md. Date signed 5-1-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

GIVEN NAME: Letter from Dr.Bryan plus bapt. cer, filmed 5-22-47 G110- LL

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a 04209

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 days

Hospital, Institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.

How long in hospital or institution? 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D.C. County:

City or town: Washington,
(If outside city or town limits, write RURAL and give nearest town)

Street No. 515 Savannah St.,S.E.
(If rural, give LOCATION)

2.(a) If veteran, name war: unknown

3. (a) FULL NAME SELBY, ~~Harry~~ (n) CHARLES HENRY

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	married

6.(b) Name of husband or wife: Lillian Selby

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 27 July 1877

8. AGE: Years	Months	Days	If less than one day
69	9	10	..... hrs. ..... min.

9. Birthplace: Md. (Town, county, and state)

10. Usual occupation: unknown

11. Industry or business

FATHER — 12. Name: Richard Selby dec.

13. Birthplace: Md.

MOTHER — 14. Maiden name: Valinda Field dec.

15. Birthplace: Md.

16. Informant: Wife: Mrs. Lillian Selby

Address: 515 Savannah St., S.E., Wash., D.C.

17. burial (Burial, cremation, or removal. Which?) Date thereof 5-9-47 (month) (day) (year)

Cemetery or crematory: Arlington National

Location: Arlington, Virginia

18. Funeral director: Thomas F. Murray

Address: 2007 Nichols Avenue, S.E., Wash., D.C.

19. 5-8 1947 (Date rec'd by registrar) Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 7 May 1947 at 8:55P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2 May 1947 to 7 May 1947 and that I last saw h... im alive on 7 May 1947

Immediate cause of death	DURATION
Coronary Heart Disease, ab	5 months
Due to: ARTERIOSCLEROSIS, GENERALIZED	
Due to:	
Other conditions: COMPLETE HEART BLOCK	5 months
ADAMS-STOKES SYNCOPE, Congestive heart failure	6 weeks

(Include pregnancy within 3 months of death)

Major findings of operation: ..... Date of op. .....

Autopsy results: Generalized Arteriosclerosis, coronary thrombosis with recent and old myocardial infarcts, congestive

PHYSICIAN: Please underline the cause to which death should be charged statistically failure

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: J. B. Bryan J. B. BRYAN, Lt.(jg)(MC) USNR
M. D. or other

Address: USNH Bethesda, Md. Date signed 5-8-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

6/15/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

157a

CERTIFICATE OF DEATH

(43W) Reg. Diat. No. 223-

1. PLACE OF DEATH:

County: Montgomery

City or town: Takoma Park, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 12 days 3 hrs 43 min.

Hospital, Institution, or street address where death occurred:
Washington San. Hospital, Takoma Park 12, Md.

How long in hospital or institution? 12 days, 3 hrs 43 min.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Takoma Park
(If outside city or town limits, write RURAL and give nearest town)

Street No. 109 Holly Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Seltzer, Donna Sue

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Fe	White	single.

6.(b) Name of husband or wife:

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): April 26, 1947.

8. AGE: Years	Months	Days	If less than one day
		12 8	3 hrs. 43 min.

9. Birthplace: Takoma Park, Md. Montgomery Co.
(Town, county, and state)

10. Usual occupation: infant

11. Industry or business:

FATHER
12. Name: Charles P. Seltzer.
13. Birthplace: D.C.

MOTHER
14. Maiden name: Mary E. Paitthorp
15. Birthplace: Spokane, Washington.

16. Informant: Baby's admission Record.
Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 9-1947 (month) (day) (year)

Cemetery or crematory: George Washington Cemetery

Location: Riggs Road, Hyattsvile, Md.

18. Funeral director: Luther Walters

Address: 254 Carroll St. N.W. Tak. Park Md.

19. May 9 1947 (Date rec'd by registrar) J. Hilton Woodall Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 8 1947, at 4:00 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 27 1947 to May 8 1947

and that I last saw h[illegible] R alive on May 8 1947

Immediate cause of death	DURATION
Cardiac dilatation	
Due to malformed baby, hair lip, cleft palate, partial club feet, mild	
Due to Spina bifida, cystocele, meningocele	
Birth W.T. 3 lb. 7 oz.	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Wm. A. Shannon M.D.
M. D. or other

Address: 112 Carroll St. N.W. Date signed: 5-8-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

55e 04212

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 month, 10 days

Hospital, institution, or street address where death occurred:

US Naval Hospital, Bethesda, Md.

How long in hospital or institution? 1 month, 10 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: D.C. County:

City or town: Washington,

(If outside city or town limits, write RURAL and give nearest town)

Street No. 50 "U" Street, N.W.

(If rural, give LOCATION)

2.(a) If veteran, name war: WW II

3.(a) FULL NAME: SHUMATE, Cecil O'Donald, Sgt. USMC

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	married

6.(b) Name of husband or wife: Jane Shumate

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Feb. 2, 1915

8. AGE: Years	Months	Days	If less than one day
32	3	6	..... hrs. ..... min.

9. Birthplace: Va. (Town, county, and state)

10. Usual occupation: Marine Corps

11. Industry or business:

FATHER — 12. Name: Jessie Shumate

FATHER — 13. Birthplace: Va.

MOTHER — 14. Maiden name: Ada Mayer

MOTHER — 15. Birthplace: Va.

16. Informant: wife: Mrs. Jane Shumate

Address: 50 U St., N. W., Wash., D.C.

17. burial (Burial, cremation, or removal. Which?) Date thereof: 5-12-47 (month) (day) (year)

Cemetery or crematory: Arlington National

Location: Arlington, Va.

18. Funeral director: W. W. CHAMBERS

Address: 1400 Chapin St., N.W., Wash., D.C.

19. 5-8 19 47 (Date rec'd by registrar) Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 8 May 19 47, at 7 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 28 March 19 47, to 8 May 19 47

and that I last saw h... im alive on 8 May 19 47

Immediate cause of death	DURATION
Melanosarcoma	5 mos.
Primary site never established. Wide	
Due to subcutaneous nodule formation developed	
early in the course of the disease.	
Due to diagnosis established on biopsy	
left axilla node which became enlarged	
Other conditions following trauma to left forearm	
with resultant soft tissue injury	

(Include pregnancy within 3 months of death) [7-2-47 Adm]

Major findings of operations:

Date of op.:

Autopsy results: Widespread melanosarcoma

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Dr. P. R. ENGLE, Cdr. (MC) USN

M. D. or other

Address: USNH Bethesda, Md. Date signed: 5-8-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

5/15/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

61

04213

CERTIFICATE OF DEATH

Reg. Diat. No. 212

1. PLACE OF DEATH:
County: Montgomery
City or town: Boyd - Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 65 yrs
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infante give residence of mother)
State: Md County: County
City or town: Boyd, RFD.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Mary Catherine Spring

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widowed

6.(b) Name of husband or wife: James E. Spring
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Sept 22 - 1872

8. AGE: Years	Months	Days	If less than one day
74	8	7	..... hrs. ..... min.

9. Birthplace: Loudoun Co. Va. (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business
FATHER 12. Name: Joseph Edwards
13. Birthplace: Va
MOTHER 14. Maiden name: Jennie Stoneburner
15. Birthplace: Va
16. Informant: Earl Spring
Address: Boyd, Md, RFD
17. Burial (Burial, cremation, or removal. Which?) Date thereof: June 1-47 (month) (day) (year)
Cemetery or crematory: Methodist
Location: Clarksburg, Md
18. Funeral director: William B. Hilton
Address: Barnesville, Md
19. May 30 1947 (Date rec'd by registrar) Mrs. C. C. Hilton By Mrs. W. Ed. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 29 1947 at 4:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 22, 1946 to May 29 1947 and that I last saw h. E.R. alive on May 27 1947

	DURATION
Immediate cause of death: Diabetes mellitus,	3 weeks.
diabetic gangrene left foot leg;	
Due to: and arteriosclerotic cardiovascular disease.	10 years.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: James R. Kerr M.D. M. D. or other
Address: Damascus, Md. Date signed: 5/29/47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04214

Reg. Diat. No. 223

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Montgomery

City or town: Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 20 hours

Hospital, institution, or street address where death occurred:

Washington Sanitarium and Hospital

How long in hospital or institution? 20 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: D.C. County:

City or town: Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No. 4624 49th St. N.W.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME

Maud Louise Stratton.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Cauc.	Married

6.(b) Name of husband or wife: George E. Stratton

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): January 22 1877

8. AGE:

Years	Months	Days	If less than one day
70	3	27	hrs. min.

9. Birthplace: Halifax, N.S. (Town, county, and state)

10. Usual occupation: Merchant

11. Industry or business: Own-(Mrs. Stratton's Shop)

FATHER

12. Name: Andrew J. Parker

13. Birthplace: ?

MOTHER

14. Maiden name: Savilla Gross

15. Birthplace: ?

16. Informant: Records-Washington San. & Hosp.

Address: Takoma Park, Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof: May 19 1947 (month) (day) (year)

Cemetery or crematory:

Location: Washington, D.C.

18. Funeral director: The S. P. Hines Co.

Address: 2901 14th St. N.W.

19. May 19 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 19 1947, at 6:25 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 18 1947, to May 19 1947 and that I last saw h[illegible] alive on May 18 1947

Immediate cause of death	DURATION
Diabetic Coma	Terminal
Due to: Pulmonary Edema	Terminal
Due to: Acute Cong. Card. Failure	Terminal
Other conditions: Arteriosclerosis	2 years

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results: Confirm Diagnosis

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Robert A. Hare M.D. M. D. or other

Address: Takoma Park, Md. Date signed: 7/9/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

1098

04215

Reg. Dist. No. 223

1. PLACE OF DEATH:

County: Montgomery

City or town: Takoma Park, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 21 days

Hospital, institution, or street address where death occurred:

Washington Sanitarium and Hospital

How long in hospital or institution? 21 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Silver Spring

(If outside city or town limits, write RURAL and give nearest town)

Street No. 638 Ritchie Ave

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Mr. Shirley Hamilton Suddath

3.(b) Social Security Number: 215-18-8455

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	widowed

6.(b) Name of husband or wife: Marjorie Leigh Hall

6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): September 2, 1886

8. AGE: Years	Months	Days	If less than one day
60	8	2	— hrs. — min.

9. Birthplace: Warrenton, Virginia (Warren Co.)

(Town, county, and state)

10. Usual occupation: Tennis Pro (retired)

11. Industry or business: —

FATHER

12. Name: John Suddath

13. Birthplace: The Plains, Virginia

MOTHER

14. Maiden name: Sallie Wines

15. Birthplace: Warrenton, Virginia.

16. Informant: Mrs Marguerite Hamilton Howard

Address: 9937 Moss Ave, Silver Spring, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 6, 1947 (month) (day) (year)

Cemetery or crematory: Rockville Union Cem.

Location: Rockville, Maryland

18. Funeral director: Wm. P. Pumphrey

Address: Bethesda, Md.

19. 5/5 (Date rec'd by registrar) 1947 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 4 May 1947, at 12:05 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12 April 1947, to 4 May 1947 and that I last saw h.im alive on 3 May 1947

	DURATION
Immediate cause of death: Hypostatic pneumonia and bronchiectasis	4 weeks.
Due to: Diffuse granulomatosis, lung.	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results: (see above)

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Manning F. Allen M.D. M. D. or other

Address: 8001 Newell Rd. S. S., Md. Date signed: 4 May 1947

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

04216

CERTIFICATE OF DEATH

Reg. Dist. No. 218

1. PLACE OF DEATH:
County: Monty B.
City or town: Germantown, Md. - Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 14 yrs
Hospital, Institution, or street address where death occurred:
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md — County: Monty
City or town: Germantown
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Rural —
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Stanford Clark Suttphin

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	married

6.(b) Name of husband or wife: Trophy L. Suttphin
6.(c) If alive, give age: 49 years

7. Birth date of deceased (mo., day, yr.): Aug 10 · 1889

8. AGE: Years	Months	Days	If less than one day
1889 57	9	17	hrs. min.

9. Birthplace: Eugene - Va —
(Town, county, and state)
10. Usual occupation: Farmer —
11. Industry or business

FATHER
12. Name: Jasper Suttphin
13. Birthplace: Va

MOTHER
14. Maiden name: Emma J. Mabury —
15. Birthplace: Va

16. Informant: Trophy L. Suttphin
Address: Germantown md

17. Burial — Date thereof 6/29/47
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory: Forest Oak Cemetery
Location: Gaithersburg Md
18. Funeral director: Ernest L. Gaither
Address: Gaithersburg md —
19. May 29 1947 Alma L. Cooke
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 27 1947 at 8 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1941, to May 27 1947
and that I last saw h alive on May 26 1947

Immediate cause of death	DURATION
Acute Coronary Thrombosis	
Due to Arteriosclerosis of coronary arteries	2 yrs
Due to Gen. arterial sclerosis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: —
Date of op. —
Autopsy results: —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: — Date of —
Where did injury occur? — (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) —
Means of injury — Injured at work?

23. SIGNATURE: Helen S Mount M.D.
M. D. or other
Address: Damascus Md Date signed: 5/29/47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1246

04217

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda Maryland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Since 5-21-'47

Hospital, Institution, or street address where death occurred: Suburban Hosp.-8600 Old Georgetown Rd.

How long in hospital or institution? Since 5-21-'47 Bethesda Md. 2. (a) If veteran, name war

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: 6000 N. Hampshire Ave. N.E. County

City or town: Washington DC (If outside city or town limits, write RURAL and give nearest town)

Street No.: Eastern Star Home (If rural, give LOCATION)

3. (a) FULL NAME: Mrs Eunice Thomas

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	widow

6.(b) Name of husband ~~or wife~~: Waverly Thomas

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Sept. 12, 1883.

8. AGE: Years: 63 | Months: 8 | Days: 15 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Yorkville S. Carolina (Town, county, and state)

10. Usual occupation: House wife

11. Industry or business

FATHER — 12. Name: Robert Ross

13. Birthplace: Yorkville S. Carolina

MOTHER — 14. Maiden name: Jennie Cook

15. Birthplace: Sharon, S. Carolina

16. Informant

Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5/29/47 (month) (day) (year)

Cemetery or crematory: Arlington National

Location: Arlington Va.

18. Funeral director: The S. P. Hines Co.

Address: 2901 14th. St. N.W.

19. 5/28/47 (Date rec'd by registrar) Wm E Jordan Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 27 19 47, at 3 15 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 1 19 46, to May 27 19 47

and that I last saw h... alive on 26 May 19 47

Immediate cause of death	DURATION
(a) Adenocarcinoma; carcinomatosis;	2 mos.
Due to (b) Atheromatosis and arteriolar sclerosis; especially of renal vessels.	3+ yrs
Due to (c) Cirrhosis of liver, moderate.	18 mo.
Other conditions: Microcytic hypochromic anemia.	2+ yrs.

(Include pregnancy within 3 months of death)

Major findings of operations: .....

Date of op...

Autopsy results: Dx alone + Cardiac hypertrophy.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: R A Lachman M. D.

Address: 5522 Western Ave Chevy Chase 15 Md. Date signed: 28 May 47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

82

04218

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 month, 25 days

Hospital, institution, or street address where death occurred:

US Naval Hospital, Bethesda, Md.

How long in hospital or institution? 1 month, 25 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: D.C. County:

City or town: Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No. 2203 K Street, N. W.

(If rural, give LOCATION)

2.(a) If veteran, name war: WW II

3.(a) FULL NAME: William David Thompson

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	married

6.(b) Name of husband or wife: Hilda Thompson

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 27 July 1913

8. AGE:

Years	Months	Days	If less than one day
33	9	9	hrs. min.

9. Birthplace: Virginia (Town, county, and state)

10. Usual occupation: Veteran

11. Industry or business:

FATHER

12. Name: Lindsey Thompson

13. Birthplace: Va.

MOTHER

14. Maiden name: Edmonds, Anna, dec.

15. Birthplace: Va.

16. Informant: wife: Mrs. Hilda Thompson

Address: 112 Horningham, Near Wiltshire, England

17. burial (Burial, cremation, or removal. Which?) Date thereof 5-14-47 (month) (day) (year)

Cemetery or crematory: Arlington National Cemetery

Location: Arlington, Va.

18. Funeral director: W. W. Chambers, Co.

Address: 3072 M St., NW, Washington, D.C.

19. May 9 1947 (Date rec'd by registrar) Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 6 May 1947 at 2:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11 March 1947, to 6 May 1947, and that I last saw him alive on 6 May 1947

	DURATION
Immediate cause of death: Broncho Pneumonia	6 wks
Due to: Aspiration	
Due to: Bulbar Paralysis	7 wks.
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results: Bronchopneumonia, secondary to paralysis of respiratory musculature.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: W. H. Boswell, Lt. (MC) USN M. D. or other

Address: USNH Bethesda, Md. Date signed: 5-9-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

5 26 47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

04219

CERTIFICATE OF DEATH

Reg. Dist. No. 716

1. PLACE OF DEATH:
County: MONTGOMERY
City or town: BETHESDA
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 DAYS
Hospital, Institution, or street address where death occurred:
SUBURBAN HOSPITAL
How long in hospital or institution? 7 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: MARYLAND County: MONTGOMERY
City or town: KENSINGTON
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 11117 MEDVALE RD
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: REV. FATHER FRANCIS UNDERWOOD

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Dec. 8, 1885

8. AGE: Years: 61 | Months: 5 | Days: 8 | If less than one day: hrs. min.

9. Birthplace: NEWTON GROVE, N. C.
(Town, county, and state)

10. Usual occupation: CATHOLIC PRIEST

11. Industry or business:

FATHER
12. Name: THOMAS UNDERWOOD
13. Birthplace: NEWTON GROVE, N.C.

MOTHER
14. Maiden name: ANNA E. MONK
15. Birthplace: NEWTON GROVE, N.C.

16. Informant: HOSPITAL RECORDS
Address: SUBURBAN HOSPITAL, BETHESDA, MD.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 19, 1947 (month) (day) (year)
Cemetery or crematory: St John's Cemetery
Location: Forest Glen, Maryland

18. Funeral director: Spencer Loeffler
Address: 3821- 14th St. N.W. Wash. D.C.

19. 5/16/47 (Date rec'd by registrar) Wm E Gohlee Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 5-16 1947, at 9:25 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1-1-46 1947, to 1947 and that I last saw h[illegible] alive on 5-16-47 1947

	DURATION
Immediate cause of death: 1) Chr. Glomerular Nephritis	12 years
Due to: 2) Terminal Uremia.	10 Days
Due to: 2) Hypertension - Secondary to	5 years
Due to: Generalized arteriolar sclerosis	
Other conditions: 3) Chr Thyroiditis	3 years

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Kenneth E. Boyle M.D. M. D. or other
Address: 8252 Dale Dr Silver Spring Md Date signed: 5/16/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

042201

61

Reg. Dist. No. 716

1. PLACE OF DEATH:
County Montgomery
City or town Bethesda
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? life
Hospital, institution, or street address where death occurred:
Suburban Hospital 8600 Old Georgetown Rd. Bethesda
How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Montg.
City or town Rockville, Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 409 Baltimore Rd.
(If rural, give LOCATION)
2.(a) If veteran, name war —

3.(a) FULL NAME WALTERS, HELEN L.

3.(b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife Julian F. Walters
6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.) April 12, 1870

8. AGE: Years	Months	Days	If less than one day
77			...hrs. ...min.

9. Birthplace Durwood, Montgomery Co.
(Town, county, and state)
10. Usual occupation Housewife
11. Industry or business

FATHER
12. Name Richard Peters
13. Birthplace Scotland

MOTHER
14. Maiden name Matilda ?
15. Birthplace Mo. Co. Md.

16. Informant Hospital Records
Address Bethesda, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5/13/47 (month) (day) (year)
Cemetery or crematory Forest Oak Cemetery
Location Gaithersburg, Md

18. Funeral director W. Reuben Dunphrey
Address Bethesda, Md

19. 5/12 1947 Jm E Robes
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11 May 1947, at 3:50 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1940, to 11 May 1947
and that I last saw h[illegible] alive on 11 May 1947

Immediate cause of death	DURATION
Coronary Thrombus	6 hrs
Due to Arteriosclerosis	10 yrs
Due to Hypertension	15 yrs
Other conditions Diabetes Mellitus	

(Include pregnancy within 3 months of death)

Major findings of operations ... Date of op. ...

Autopsy results ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of ...
Where did injury occur? ... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury ... Injured at work?

23. SIGNATURE [illegible] M. D. or other
Address Rockville Md Date signed 11 May 47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

Evidence for change of age shown on:

FILM No. G 110 MAY 22 1947

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 5716 — 24221

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-25.15M

1. PLACE OF DEATH:
County: Montgomery
City or town: Chevy Chase
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 9 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Chevy Chase
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 4826 Leland Street
(If rural, give LOCATION)
2.(a) If veteran, name war: No

3.(a) FULL NAME: MARTHA GEER WEIGEL

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	MARRIED

6.(b) Name of husband or wife: William Edward
6.(c) If alive, give age: 71 years

7. Birth date of deceased (mo., day, yr.): December 6, ~~1845~~ 1887

8. AGE: Years	Months	Days	If less than one day
64	5	7	....hrs. ....min.

9. Birthplace: Ohio (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business

FATHER
12. Name: Robert P. Kelly
13. Birthplace: Ohio

MOTHER
14. Maiden name: Minnie Bodenburg
15. Birthplace: Ohio

16. Informant: Mr. William Edward Weigel
Address: 4826 Leland St., Ch. Ch. Md.

17. Cremation (Burial, cremation, or removal. Which?) Date thereof: 5/16/47 (month) (day) (year)
Cemetery or crematory: Cedar Hill Cemetery
Location: Maryland

18. Funeral director: Wm. Reuben Pumphrey
Address: 7557 Wisconsin Ave. Bethesda, Md.

19. 5/16 (Date rec'd by registrar) 19 47 Wm E Jones Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 5/13/47 19.... at 11:22 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8-25-43 19.... to 5/13/47 19....
and that I last saw h~~e~~r alive on 5-9-47 19....

Immediate cause of death	DURATION
Arteio-sclerotic hypertensive heart disease	4 yrs
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ....Date of op.....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Paul D Cantor MD
M. D. or other
Address: Bethesda, Md Date signed: 5/14/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04222

1316

Reg. Dist. No. 216

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 16 days
Hospital, institution, or street address where death occurred:
Suburban Hospital
How long in hospital or institution? 16 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Dist. of Col. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 3014 Woodland Dr.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME Mr. Lawrence Wesolowski

3. (b) Social Security Number

4. Sex	5. Color or race	8.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Stefanie Wesolowski
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): August 18, 1886

8. AGE: Years: 60 | Months: 8 | Days: 24 | If less than one day: hrs. min.

9. Birthplace: Poland
(Town, county, and state)

10. Usual occupation: Butler

11. Industry or business:

FATHER
12. Name: John Wesolowski
13. Birthplace: Poland

MOTHER
14. Maiden name: Maria ?
15. Birthplace: Poland

16. Informant:
Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 16, '47 (month) (day) (year)
Cemetery or crematory: Mt. Olivet Cemetery
Location: Washington, D. C.

18. Funeral director: W. W. Chambers Co.
Address: 1400 Chapin St. N.W. Wash. D.C.

19. 5/13/47 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 12 19 47 at 11:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 24/April/1947 19 to 12/May/1947 19 and that I last saw h alive on 17/may/1947 19

Immediate cause of death	DURATION
Nephritis - Chronic	
Due to:	
Due to:	
Other conditions: Pneumonia - atypical	

(Include pregnancy within 3 months of death)

Major findings of operations: None.
Date of op.:
Autopsy results: None.
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Charles R. L. Halley M.D.
M. D. or other
Address: 1501 - Eye St N.W. Date signed: 13/May/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04223

Reg. Dist. No. 216

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH

County: Montgomery County

City or town: Chevy Chase, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: 5 W. Thornapple Street

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Chevy Chase, Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 15 W. Thornapple St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME William Earl West

3.(b) Social Security Number

4. Sex: Male

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Married

6.(b) Name of husband or wife: Theresa B West

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Oct 23, 1881

8. AGE: Years: 65 Months: Days: If less than one day: hr. min.

9. Birthplace: Brownsville Ohio

(Town, county, and state)

10. Usual occupation: Retired

11. Industry or business

FATHER

12. Name: Geo. Bruce West

13. Birthplace: Keyport, Ohio

MOTHER

14. Maiden name: Addie K. West

15. Birthplace: Brownsville, Ohio

16. Informant: Charles K. West

Address: 8 Primrose St, Chevy Chase Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof May 7 1947 (month) (day) (year)

Cemetery or crematory: Rock Creek Cemetery

Location: Washington, D.C.

18. Funeral director: Martin W. Kyser Co.

Address: 1300 N. Street, N.W. Wash. D.C.

19. 5/8 1947 (Date rec'd by registrar) Wm E Jones Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 7 1947, at 9:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 4 1947, to May 7 1947 and that I last saw h... alive on May 7 1947

	DURATION
Immediate cause of death: Cardiac Failure	24 hrs.
Due to: Pulmonary Tuberculosis	6 mos.
Due to:	
Other conditions: Chronic Pulmonary Tuberculosis 25 yrs. ago.	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Samuel Diener M.D.

M. D. or other

Address: 2808 Ordway St. N.W. Wash. D.C. Date signed: 5/7/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1700

CERTIFICATE OF DEATH

04224

Reg. Dist. No. 216

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Sudden death
Hospital, institution, or street address where death occurred:
Dorset Ave. railroad crossing
How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Washington, D. C. County:
City or town:
(If outside city or town limits, write RURAL and giva nearest town)
Street No. 1214 25th St. N. W.
(If rural, give LOCATION)
2.(a) If veteran, name war: No

3. (a) FULL NAME: ELSIE WILLIAMS

3. (b) Social Security Number: 578-14-4777

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Widowed

6.(b) Name of husband or wife: Walter Williams
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Dec. 25, 1900

8. AGE: Years	Months	Days	If less than one day
46	4	19	..... hrs. ..... min.

9. Birthplace: Brooklyn, New York
(Town, county, and state)
10. Usual occupation: Parlor Maid
11. Industry or business

FATHER
12. Name: Wm. Henry Jackson
13. Birthplace: Jacksonville, Florida

MOTHER
14. Maiden name: Mary McCoy
15. Birthplace: Lynchburg, Va.

16. Informant: Mother
Address: Same above address

17. Removal
(Burial, cremation, or removal. Which?)
Date thereof: May 14, 1947
(month) (day) (year)
Cemetery or crematory: Washington, D. C.
Location:

18. Funeral director: A. B. Boyd Funeral Home
Address: 1238 20th St. N. W. D.C.

19. 5/14 19 47 Wm E Johns
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 14, 1947, at 4:30P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Dep. Med. Exam. Case	
Fracture of Skull. (accidental)	Died suddenly
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of: 5/14/47
Where did injury occur? Bethesda, Montgomery, Md.
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?): Public road
Means of injury: Railroad crossing Injured at work? No

Frank J. Brockett M.D.

23. SIGNATURE: Dep. Med. Exam. M. D. or other
Address: Gaithersburg, Md. Date signed: 5/14/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Evidence for change of age and birthdate shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

CERTIFICATE OF DEATH

File No. G 110 JUN 20 1947

Reg. Dist. No. 216

1. PLACE OF DEATH:

County Montgomery

City or town Bethesda, Maryland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Since 5-7-'47

Hospital, Institution, or street address where death occurred: Suburban Hosp., 8600 Old Georgetown Rd

How long in hospital or Institution? Since 5-7-'47 Bethesda Md

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Bethesda Maryland (If outside city or town limits, write RURAL and give nearest town)

Street No. 531 Maple Ridge Road (If rural, give LOCATION)

2.(a) If veteran, name war — World War I

3. (a) FULL NAME Mr Percy Willis

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	

6.(b) Name of husband or wife Amelia Willis

6.(c) If alive, give age 57 years

7. Birth date of deceased (mo., day, yr.) Jan. 23, 1887

8. AGE: Years	Months	Days	If less than one day
59 60	4	8/5	....hrs. ....min.

9. Birthplace Washington D.C. (Town, county, and state)

10. Usual occupation Realtor

11. Industry or business

FATHER 12. Name Edward M. Willis

FATHER 13. Birthplace Battle Creek, Mich.

MOTHER 14. Maiden name Maria Troth

MOTHER 15. Birthplace Philadelphia, Pa.

16. Informant Amelia Willis (wife)

Address Same

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5/31/47 (month) (day) (year)

Cemetery or crematory Rock Creek Cemetery

Location Washington, D.C.

18. Funeral director Wm. Reuben Plumphrey

Address Bethesda, Maryland

19. 5/29 19 47 (Date rec'd by registrar) Wm E Jobes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-28 1947 at 8:30 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4 May 1947, to 28 May 1947 and that I last saw h.i.m. alive on 27 May 1947

Immediate cause of death	DURATION
Coronary Occlusion caused by	one min.
Due to Coronary Sclerosis & stenosis	3 years.
Due to Generalized Arteriosclerosis	10 yr.
Other conditions Cholelithiasis	20 yr.

(Include pregnancy within 3 months of death)

Major findings of operations None

Date of op.

Autopsy results Same as above.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE John S. Bell M.D. M. D, or other

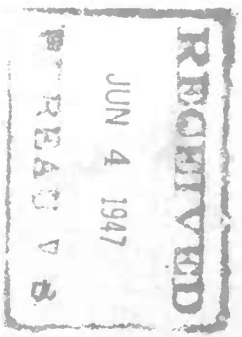
Address 7936 Eastern Ave Bethesda Md Date signed 28 May 47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1947-5-28
1887-1-23
60-4-5



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

159

04226

CERTIFICATE OF DEATH

OD

Reg. Diat. No. 220

1. PLACE OF DEATH:

County: Montgomery

City or town: TAKOMA PARK

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 74 hours + 15 min.

Hospital, institution, or street address where death occurred:

WASHINGTON SANITARIUM + HOSPITAL

How long in hospital or institution? 74 hours + 15 min.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: DISTRICT of COLUMBIA County:

City or town: WASHINGTON, D.C.

(If outside city or town limits, write RURAL and give nearest town)

Street No. 312 Buchanan St. N.W.

(If rural, give LOCATION)

2.(a) If veteran, name war: V.

3. (a) FULL NAME

WINTERS, Baby Boy

3. (b) Social Security Number

—

4. Sex	5. Color or race	8.(a) Single, married, widowed, or divorced
M	WHITE	—

6.(b) Name of husband or wife: ooo

5 mos. 6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 3, 1947

8. AGE: Years	Months	Days	If less than one day
0	0	3	hrs. min.

9. Birthplace: TAKOMA PARK, MARYLAND (Town, county, and state)

10. Usual occupation: —

11. Industry or business

FATHER

12. Name: MR. HERBERT HARRIS WINTERS

13. Birthplace: DURHAM, N.C.

MOTHER

14. Maiden name: LORAINNE ADELINE DARNELL

15. Birthplace: LEDYARD, IOWA

16. Informant: WASHINGTON SANITARIUM + HOSPITAL

Address: TAKOMA PARK, MARYLAND

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 7 1947 (month) (day) (year)

Cemetery or crematory: Geo. Washington Memorial Cemetery

Location: Hyattsville, Maryland

18. Funeral director: Arthur Walters

Address: 254 Carroll St. N.W. Wash. 12, D.C.

19. 5/7/ 19 47 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 6 19 47, at 3:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 3 19 47, to May 6 19 47

and that I last saw him alive on May 6 19 47

Immediate cause of death	DURATION
Respiratory Failure	
Due to: PREMATURITY	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Dean V. Harding M.D. M.D. or other

Address: 113 Carroll St NW Wash DC Date signed: 5-6-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

04227

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

96

Reg. Dist. No. 216

1. PLACE OF DEATH:
County Montgomery
City or town Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 days
Hospital, Institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.
How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State D.C. County
City or town Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 704 Alabama Avenue, S.E.
(If rural, give LOCATION)
2.(a) If veteran, name war WW 1

3.(a) FULL NAME: WRIGHT, Richard Owen

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	married

6.(b) Name of husband or wife: Harriet Wright
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): January 10, 1873

8. AGE: Years	Months	Days	If less than one day
74	4	3	..... hrs. ..... min.

9. Birthplace: Washington, D.C.
(Town, county, and state)
10. Usual occupation: Retired Navy
11. Industry or business: unemployed

FATHER
12. Name: WRIGHT, Richard dec
13. Birthplace: Washington, D.C.

MOTHER
14. Maiden name: PALIVER, Mary dec.
15. Birthplace: Washington, D.C.

16. Informant: wife: Mrs. Harriet Wright
Address: 704 Alabama Avenue, S.E., Wash., D.C.

17. burial (Burial, cremation, or removal. Which?) Date thereof 5-16-47 (month) (day) (year)
Cemetery or crematory: Arlington National
Location: Arlington, Va.

18. Funeral director: LEE FUNERAL HOME cwk
Address: 4th & Mass., Ave., N.E., Wash., D.C.

19. 5-13 19 47 Mary Charlotte Smith
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 13 May 19 47 at 12:52 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10 May 19 47, to 13 May 19 47
and that I last saw h... im ...alive on 13 May 19 47

Immediate cause of death	DURATION
Hemorrhage, Cerebellum, Right (anterior inferior cerebellar artery)	3 days
Due to Hypertensive Heart disease	5 months
Due to Arteriosclerosis, General	? 20 years
Other conditions Chronic glomerulo nephritis	
AORTIC ANEURYSM - due to arteriosclerosis - not syphilis - (5/16/47 dec)	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: same as above
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: J. B. Bryan J. B. BRYAN, Lt.(jg)(MC) USN
M. D. or other
Address: USNH Bethesda, Md. Date signed 5-13-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

(I)

5/16/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

55B

04228

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 months, 22 days

Hospital, Institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.

How long in hospital or institution? 3 months, 22 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Pa. County:

City or town: South Fork
(If outside city or town limits, write RURAL and give nearest town)

Street No. P.O. Box 406,
(If rural, give LOCATION)

2.(a) If veteran, name war: WW II

3.(a) FULL NAME: Thomas (n) YUROCHKO

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 8, 1923

8. AGE: Years	Months	Days	If less than one day
23	9	24	hrs. min.

9. Birthplace: Pa.
(Town, county, and state)

10. Usual occupation: Veteran

11. Industry or business: (not employed)

FATHER
12. Name: Stephen Yurochko dec.
13. Birthplace: Austria

MOTHER
14. Maiden name: Margaret Colbaugh
15. Birthplace: Pa.

16. Informant: mother: Mrs. Margaret Yurochko
Address: P.O. Box 406, South Fork, Penn.

17. removal (Burial, cremation, or removal. Which?) Date thereof 5-3-47 (month) (day) (year)

Cemetery or crematory:

Location: South Fork, Penn.

18. Funeral director: W. W. CHAMBERS, CO. J. D. Poore
Address: 1400 Chapin St., NW, Washington, D.C.

19. 5-3- 19 47 (Date rec'd by registrar) Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 2 May 19 47 at 3:40P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10 January 19 47 to 2 May 19 47 and that I last saw h alive on 19

Immediate cause of death	DURATION
Pneumonia	
Due to: Pneumonia	72 hrs.
Due to:	
Other conditions: Ewings Sarcoma Type.	

(Include pregnancy within 3 months of death)

Major findings of operation: Ewings Sarcoma involving ribs 3, 4, & 5 Date of op.?

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: W. B. Ford
W. B. FORD, Lt.(MC) USN
M. D. or other

Address: USNH Bethesda, Md. Date signed 5-3-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

5/12/47